

CONCLUSIONS

EUROPEAN CONFERENCE ON CARE AND PROTECTION OF SENIOR CITIZENS

The Dignity and Hazard of Elderly

Conference in the framework of the Czech presidency supported by
European Commission

*Under the patronage of EU Commissioner Vladimír Špidla
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Introduction

The autonomy, dignity and mistreatment of older people go to the heart of the relationship between the citizen and the state. Each has rights and responsibilities that come into sharp focus as populations age and barriers arise to personal fulfilment and social participation. Not to address them would threaten the mutual support between generations, and popular consent toward wider political and social systems. It may also ignore the abuse and neglect of some of our most vulnerable citizens. There is a need to address the adoption of preventive measures and supportive environments for both active and frail older people, who live alone, in families, in institutional care and in their communities.

The Declaration of the European Conference on Care and Protection of Senior Citizens brings together the thoughts and conclusions of policy-makers, non-governmental organisations, business and scientific interests from across the European Union. There follows a series of summary points, arising from the conference and collated by a working group, which acts as a front-piece to the Declaration itself. The front-piece suggests Areas of Special Priority and Actions that can be taken forward by the European Commission.

Areas of Special Priority

Recognising Frailty in Old Age

A focus on active ageing and strategies aimed at the 'young old' have led to an under emphasis on forms of frailty associated with old age. In deep old age, dignity becomes an increasingly important issue as the possibilities for autonomy become reduced. Responding to frailty and recognising dignity require a combination of medical, psychological and social factors to improve wellbeing and continued social integration.

We recommend:

- Health and social services actively strengthen dignity through tailored measures that support one's meaning of life, sense of coherence and self-respect.
- A combination of medical and other interventions be used to enhance dignity via diagnostic approaches for its impairment and including interventions for its restoration.
- Dignity is to be positively constructed, supported, intensified and strengthened including comprehensive preventive measures in the frail people at risk.
- Introduce the term „dignitogenesis“, stressing the extraordinary importance of dignity and the need of active approaches that prevent forms of abuse and neglect

Recognising Diversity in later life.

As populations grow older they also become more diverse. This reflects an increasing interdependence of physical, psychological and social factors that give rise to a wide variety of coping strategies and lifestyle. It also reflects increasing diversity in the wider population occasioned by population movement, uneven economic distribution and changing attitudes to and expectations of later life.

We recommend that each of the following issues is formally recognised in future policy development:

- It is often overlooked that later life consists of different stages. These would include a third age associated with autonomy and activity, and a fourth age associated with threat on dignity due to increasing frailty. Each has different health, social needs and appropriate forms of social inclusion.
- Economic diversity and cumulative inequality across the lifecourse influence the life chances and well being of citizens in late life. These differences are influenced by gender, ethnicity, culture and locality.
- Patterns of care and support vary between member states and within different localities. The meaning attributed to old age, the role of intergenerational relationships and the balance between public and private provision, expectations state, community and family support also create variation in the experience of old age, positive and negative.

Promoting Facilitative Environments

In order to adapt to a changing balance between age-groups, it is important to create facilitative environments that promote social participation and allow intergenerational relationships to work well. Well designed environments can increase intergenerational solidarity, promote public health and increase efficient energy use. Environments that enhance the ability of older people to ambulate and exercise, for example, also create a more active and healthy older population. Services that facilitate the negotiated shared use of public space can increase solidarity between generations.

We recommend:

- At an infrastructural level, the promotion of age friendly urban and rural design, including housing, transport and the use of public and private space.
- Enhancing social integration through the research and dissemination of factors that facilitate intergenerational cooperation and shared problem solving in community settings.
- An examination of the role of the media in influencing attitudes toward different age groups and intergenerational interaction.
- That mistreatment be recognised as a problem of failing care and support, which can be addressed through the development of supportive systems and environments.

Promoting Family Solidarity.

Families and the balance between family care, health and welfare support are key components in the maintenance of intergenerational solidarity within families and in removing the circumstances within which mistreatment may arise. Family relations form a continuum from supportive and caring to dysfunctional and even toxic family structures and environments. In order to promote the former and remove the circumstances in which abuse and neglect occur, we would recommend:

- Generate further knowledge about the dynamics of families with older members and the identification of risk factors for mistreatment.
- The development of partnerships between families, elders, the State, communities and civil society
- Facilitate families in their caregiving role by developing services, work friendly policies, and further the development of a continuum of support including Long Term Care
- Promote a comprehensive policy agenda combining family policy and aging policies

Building a continuum of Long Term Care (LTC)

We have to re-assess the concept of LTC and recognise the importance of both continuity of care and that care needs reflect a continuum that changes as adults age. This would include formulating a new culture of care through promoting an holistic model that increases quality of care and would be sensitive to aging needs and overcome forms of mistreatment. In order that LTC services should be physically and socially accessible to all, we would recommend:

- Improved coordination between health and social care services.
- Rehabilitation into community settings should be prioritized wherever possible
- Facilitating a continuum of care that addresses changing need, including palliative care
- Increased communication and coordination of inter professional interventions involving consumers, elders and families in care planning.

Health Prevention beyond a Disease Model.

We find it necessary to highlight, not only at the medical, but above all at the general and political level, specific health problems of the frail elderly people beyond the disease-model. It is very important to understand that to want a medical care of high quality for the elderly, is also to recognise that health is more than an absence of disease. Misunderstanding and under-estimation of social and psychological factors can lead to cases of systematic abuse and neglect with a substantial decay of abilities of older patients and health-related quality of life.

We recommend:

- Greater attention to preventive measures, their dissemination and factors affecting uptake.
- A combination, rehabilitative, and integrated interventions to reduce reliance and negative impacts on hospitalisation
- Greater use of the psychological and social intervention on recovery
- More effective translation of scientific innovation into effective medical intervention.

Preventing the Misuse of Pharmacology

While advances in pharmacology can significantly improve the well being of older patients, it is liable to mis-prescription, a non consideration of alternatives and may used as a form of social control. Increased awareness of multimorbidity and the use of alternative approaches to uneffective overprescription of pharmacological drugs. Even the drugs prescribed in harmony with guidelines for treatment of particular diseases can lead, in the framework of polypragmasia to serious deterioration of frail geriatric patients.

We Recommend:

- Prevention of chemical abuse: the use of pharmacological products as a means of restrain and control.
- Prevention of misprescription, which can constitute a form of financial abuse
- Greater use of prevention, comprehensive rehabilitation, psychotherapy and other non-pharmacological interventions to improve the wellbeing of older patients.
- Holistic support for frail people beyond a disease-model, to relieve for example, from falling, muscle weakness, depression and anxiety, resignation.

Promoting Conceptual Development

The study of autonomy, dignity and mistreatment in old age is conceptually underdeveloped. This is often overlooked in the search for practical measures. However, clear theoretical understandings are necessary if responses are to be sustainable in the long term. This is particularly true of the multiple and interacting factors that influence intergenerational solidarity and well-being in later life. Understanding of the systems and dynamics influencing behaviour is much more advanced for other parts of the life course- for example childhood- and it is time for old age to catch up.

We recommend that development work is needed into the following:

- The complex systems of intergenerational relationships, in families, workplaces and in communities.
- The adaptation of organisational cultures, in public and business sectors, to periods of rapid demographic change.
- The relationship between human rights, social inclusion and elder mistreatment.
- The philosophical meaning of longevity and later life

Building Education, Training and Learning

If education and training remain at current European levels, an undercapacity in helping professionals is inevitable. Therefore appropriate training of professionals, para-professionals, care workers and family carers, requires special attention in order to to develop knowledge, share and disseminate this knowledge. There is also a need to see education in a broader context, embracing understanding between different generations.

We recommend:

- Mainstreaming lifecourse and aging into schools, higher education and professional curricula.
- Development of specialist programs and departments in both Gerontology and Geriatrics at Masters and doctorate levels.
- Facilitating prevention through educational programs such as health promotion and educating the young in schools, and promoting learning programs for elders in university settings such as the University for the Third Age.
- Broadening research bases and dissemination of evidence through community-university partnerships as well as partnering with the business sector.

Suggested Actions

1. The European Commission should include the issue of dignity and mistreatment in the priorities addressed in the framework of the Open Method of Coordination on Long Term Care:
 - The EC should ask Member States what they do or plan to do to tackle the issue of dignity and mistreatment in the questionnaire that MS are asked to return once every three years to the EC with information on their LTC system and policies;
 - The Social Protection Committee should organise regular Peer Reviews on the issue of mistreatment, the quality of LTC and age-friendly environments;
 - The EC should support research on conceptual understanding of elder abuse and neglect and complete the collection of prevalence data across the EU-27 and policies/measures which have proved useful to fight against elder abuse.

2. The EC should include a whole chapter on dignity and mistreatment in the Communication on LTC they plan to issue in 2010:
 - This chapter should build on the EC Conference of March 08 and French Presidency Conference of October 09 on Alzheimer's Disease, CZ Presidency Conference of May 09 as well as the Swedish Presidency Conference of September 09
 - It should also make concrete proposals for EU action to tackle elder abuse institutional, community and home care settings and promote environments that support autonomy and dignity.

3. The EC and MS should adapt Structural Funds regulations and priorities to encourage their use for the implementation of quality LTC and community services for the elderly:
 - The Ad Hoc Expert group working on de-institutionalisation of care services will deliver a report in October and their recommendations should be used to make it more easy for local and national authorities to use Structural Funds and European Social Fund resources to tackle the issue of elder abuse, the development of preventive environments, the promotion of well being of elderly dependent people and the concept of Design-for-All.

4. The MS and EC should improve the legal framework protecting vulnerable citizens' groups such as the dependent elderly including combating against abuse of guardianship in elderly people with dementia and confusion:

- MS should support the EC proposal for a directive to combat discrimination outside employment on various grounds including age;
- Since LTC services fall in the scope of the Services Directive and there is now a single market for services, free movement of care professionals and free movement of patients, the EC should take the initiative to propose mandatory quality standards for LTC services to protect this vulnerable group of consumers as exist already for the protection of consumers of goods and products in the EU.
- The EC should propose the development of EU coordination between MS justice systems to prevent staff who have been convicted of elder abuse in a country to move and seek work as carer in another MS

“Will and support for meaning, dignity and respect”

Declaration of the EUROPEAN CONFERENCE ON CARE AND PROTECTION OF SENIOR CITIZENS

The Dignity and Hazards in the Elderly

Continuous increases in life expectancy over the last decades strengthen the hopes of most people for a fuller use of their potential and for increasing their contribution to close relatives, families, communities and society as a whole.

However, taking advantage of prolonging life in old age usually requires active creation of certain preconditions, active removal of various barriers and obstacles which hinder personal satisfaction and self-fulfillment, and social inclusion, as well as well-being and security.

Until now, increasing life expectancy and the rising proportion of seniors in populations has been a major source of concern rather than grounds for coordinated planning supported by strong political commitment. Although ageing has been recognized as a challenge in relation to pension and health systems, and to labor markets, which are important preconditions for competitiveness and quality of life of current and future generations, it is also necessary to pay greater attention to the aspects of ageing related to human rights, equal access to health, education, housing, social and other services and goods which should be adapted to the needs of frail, disabled or other disadvantaged seniors.

Frail older people with low levels of health potential (with low levels of intertwined hardiness, resilience and adaptability) are especially disadvantaged and at risk. Hazards for old people associated with unadjusted (maladapted) services and practices suitable for younger population are often underestimated as well as their desire to live meaningful fulfilling lives. Among the key values of meaning for frail older people are also issues of dignity, respect and self-owning – maintaining the uniqueness of each personality and real competencies in decision making.

Economical and cultural development in the European Union and in many other countries offers favorable conditions for the development and systematic, generally accessible, implementation of “long-term care” (LTC) services as qualitatively higher degrees of support and security for frail people at risk or in situation of lost capacities for self-care.

The strength of the concept of long-term care (LTC) lies particularly in the coordinated, seamless provision of services and interventions and in breaking down the existing barriers between various sectors, institutions, competencies, professional boundaries and payment mechanisms. Furthermore it relies on an emphasis on the meaningful of existence of human beings, enabling life in familiar environments while maintaining autonomy and social roles. It also relies on active prevention and on early detection of various forms of mistreatment by ‘caring’ persons (relatives, or professionals), various forms of neglect, abuse or even violence (domestic violence, misuse of restraints etc.).

Dignity, self-esteem and security must not be put at risk even for the most frail seniors and seniors at greatest risk – those who are dying, unconscious, severely disoriented (confused, or

those in severe delirium) or suffering from advanced stages of dementia. Even they must not become the objects of cheap provision for basic biological human needs.

Limited public resources require that greater emphasis is placed on the expediency of long-term care (LTC), including active monitoring of care and the use of high technologies. Those, together with active counseling, supervision, and other forms of support for caring families and for professional teams, are the cornerstone to prevent excessive burden, burnout and failure.

The right concept and setting for a health service system is exceptionally important for the struggle for the quality of life in old age. The level of functional health is amongst the key factors of quality of life. At the same time, non-discriminate support for health, including availability (accessibility and affordability) of health services is a fundamental mark of the equal position of older persons in society. Furthermore, it is necessary to strive for subordination of health care provision to the essential need for meaning of life and not to allow replacement or overlaying of natural social roles in relation to decremental changes and multi-morbidity with the role of „lifelong patient”, subordinated to the powers of health professionals and of regimes of health care. It is thus important to put an emphasis on the key health problems and challenges.

Following on from the French E.U. presidency, which focused on Alzheimer disease, neurodegenerative disorders and dementia and other issues related to dignity, the Czech E.U. presidency wishes to emphasize the critical importance of the phenomenon of geriatric frailty, i.e. treatable, and thus fully in the competence of health interventions and services, aspects of the decrease in health potential (mutually interrelated hardiness, resilience and adaptability) and frailty-determined multi-causal health problems beyond the limits of the so called “disease-model”.

Many health problems in old age remain out of the interest of health institutions, untreated and not confronted, despite the repeated warnings and calls from various geriatric societies (IAGG, EUGMS, SGMEUMS). The structure of health services, developed over time with an emphasis on the needs of young populations as well as the structure of education of physicians and other health workers do not correspond to and confront current health problems.

Frailty and its clinical consequences are thus becoming a source of misunderstanding, unnecessary suffering, discrimination, neglect, preventable disability, avoidable social exclusion, unnecessarily bad prognosis of various diseases and accidents and altogether represent severe health challenges for the dignity and security of old people and the touchstone of quality of health and social care.

The Prague conference builds on previous EU presidencies, conferences, recommendations and both political and expert documents of European meetings and negotiations, including

- Meeting and recommendations of the conference „*The fight against Alzheimer’s and related diseases*“ held during French presidency of the EU in October 2008 in Paris
- Meeting and recommendations of the conference “*Intergenerational Solidarity for Cohesive and Sustainable Societies*” held during Slovenian presidency of the EU in April 2008 in Brdo, which focuses inter alia on long-term care in intergenerational perspective

- *“European silver paper on the future of health promotion and preventive actions, basic research, and clinical aspects of age-related disease”* adopted at the conference held during French presidency in September 2008 in Wroclaw, Poland, and supported by EUGMS, IAGG-ER, EAGP, ISG and ISSAM.
- Discussion paper of the European Commission *„What can the European Union do to protect dignity in old age and prevent elder abuse“* a following conference on elder abuse held in March 2008 in Brussels
- *“Healthy ageing: keystone for a sustainable Europe – EU health policy in the context of demographic change”* (2007, discussion paper)
- Communication of the EC *„Demographic future of Europe - from challenge to opportunity”* (COM(2006) 571 final)
- A position paper *„Ageing and Health in Europe – Challenges, opportunities and the role of Specialist Health Care for Older People“* for the UNECE Ministerial Conference on Ageing (Berlin, 2002) from the EUGMS and the SGMEUMS
- Meeting and recommendations of the conference *„eHealth 2009“* held during Czech presidency of the EU in February 2009 in Prague
- *Madrid International Plan of Action on Ageing (MIPAA)* adopted by the Second World Assembly on Ageing, held in Madrid in 2002
- *The United nations Principles for older people* adopted by the General Assembly of United nations in 1991
- *European charter for family carers* supported by the Confederation of Family Organisations in the European Union (COFACE) in 2009

With respect to the challenges and opportunities and in order to support dignified, active and healthy ageing amongst European citizens, the Prague conference and participating international seniors’ organizations look to responsible bodies, institutions, academia, public and other relevant stakeholders and call for the adoption and the implementation of the following recommendations.

We look particularly to:

A) European Commission and national governments

1) Changes in approach to the old age:

- a) Try to ensure that demographic development and arrival of the longevity society are not perceived one-sidedly from the perspective of demographic alarmism or the demographic ‘timebomb’, which is based on the fear of lack of resources for social security and health systems, but are also seen as an opportunity and the chance to change our approach to life in old age.
- b) Promote open discussions about convention on rights, responsibility, and participation of older people in society
- c) Consider the effect of purposeful, single-minded (strategies for the) inclusion and integration of issues related to old age and ageing into government and parliamentary structures, and modulate any division of competencies so that they respond to demographic changes in society and the urgent need to solve them
- d) Consider the establishment of an EU gerontological institution or program aimed at monitoring, education and other roles or tasks related to adjusting policies and services to the needs of ageing populations

- e) Pay attention to arguments that there is continuum of “Elder Dignity, Abuse and Neglect” (EDAN) and that mistreatment of old people, including neglect, abuse or even violence, are not usually isolated phenomena, but the consequence of insufficient respect for/towards older generations, their unclear social role and lack (absence) of flexible support systems for older people with disabilities and for caring families
- f) Include issues related to EDAN and adult protection services in the OMC and strengthen the cooperation and exchange of good practice and experience within the EU, including in the area of research
- g) Ask the European Commission to adopt positive strategies for active, healthy and dignified ageing in the EU, which will understand ageing as an opportunity and will formulate concrete recommendations to adjust individual policies, services and goods such as housing, health, education and other services and opportunities and not only focus on the fiscal implications of demographic development, or on prolonging working life
- h) Continue to remove discriminatory age barriers and to strengthen protection against (age) discrimination in various areas of life

2) Respect to cultural and religious heterogeneity

- a) Acknowledge and take into account the cultural and religious diversity (heterogeneity) of today’s Europe; recognize the sense of being uprooted experienced by ethnic and religious minorities; promote respect of the variety of experiences in old age and rights (rightful claims) arising

3) Long-term care

- a) Give more attention to discussion on the adoption of European-wide principles and standards of LTC and to the European concept of geriatrics/gerontology and comprehensive rehabilitation
- b) Participate in the creation of the European concept and standard nomenclature of LTC which will enable continuity of support and care as well as an exchange of intelligent and comprehensible experiences, and examples of good practice while emphasizing an enabling community model of LTC, independent living, and “ageing-in-place in the home and community.
- c) Support the development and use of ICT in LTC based on the results of the conference on „E-health“, which was held during the Czech presidency of the EU
- d) Minimize the impact of the global crisis on the financing of health, social and other services, which are precondition of dignified life in old age
- e) Support in the maximum feasible way the de-institutionalization of social and health care services

4) Community life

- a) Recognize and appreciate the meaning and dimensions of community living for older persons in home environment by a goal-seeking and permanent creation of appropriate conditions for its development
- b) Appreciate the value of older persons for economic and social development including the importance of community care and support for local employment and including the importance of older people for re-vitalization of small rural settlements
- c) Open ESF and other financial instruments in the EU to the needs of ageing populations, not only to the working population and labor markets

5) Education and research

- a) Effective political decision making must be based on evidence. Support purposeful and efficient policy and practice-oriented research into all areas of life in old age and ageing so that the extent and quality of research projects correspond to the significance of changes in today's society
 - b) Recognize the importance of incorporating the needs/demands of seniors and societies marked by longevity into all levels of educational systems and support the development of education in gerontology and geriatrics
- 6) Public opinion
- a) Support targeted and efficient measures, especially through the media, aimed at changing the views of society on the role of older generations within society and about life in old age

B) Local and regional authorities and their bodies:

1) Changes in approach to the old age:

- a) Be sensitive to the dignity of and risks faced by frail seniors as well as to the potential of healthy and active fit seniors.
- b) Do not forget that many lonely old people have no other advocate, help nor anyone to rely on other than their neighbors and their community (municipality) and that caring families need your support as well.

2) Examples of good governance and practices

- a) Exploit to the limit all possibilities of the information global society – opportunities to share your experiences, examples of good practice within the whole EU as well as all other developed countries
- b) Appreciate the meaning of an urban environment that supports inclusion, health, security, and the adjustment of local transport, housing and other services (policies), and join the age-friendly cities movement (network), implement the principles and recommendations of the WHO Age-friendly cities project

3) Right to a lifelong home, the support of life in the community, and long-term care

- a) Respect the right for life time homes, support for ageing in the community (in place) and for adequate social services.
- b) Support the inclusion of seniors into community life, in promoting their productivity and self-fulfillment.
- c) Create conditions for the development of comprehensive systems of integrated community support services allowing for independent meaningful life for your frail fellow citizens – involving security of contacts, early intervention in case of emergencies and a senior-friendly provision of quality services
- d) Strive to map and address gaps (“white places” and “no-man’s land”) in the services systems and negative competence conflicts on the edge (margins) of responsibilities of different government departments, ministries and other public administration bodies.
- e) Accept the creation of conditions for comprehensive coordinated LTC, including screening and monitoring (dispensarization) of frail seniors at risk and for symptoms of elder abuse, as part of the responsibility of local government and administrative systems.

- f) Take into account the diverse experiences of ageing in urban and rural environments and be sensitive to the problem of real or symbolic displacement of seniors trapped within modern urban processes such as suburbanization and gentrification.

C) The universities, academia:

- a) Pay full and thorough attention to the development of education and research for ageing and longevity societies, aimed at understanding of life in old age, support of frail old and very old people, and understanding of life in its wholeness without scientific reductionism.
- b) Help to debunk groundless and one-sided demographic alarmism, which severely strengthens prejudice and stereotypes as well as age discrimination
- c) Struggle to ensure that educational curricula aim not only at scientific knowledge and professional skills in specific disciplines, but also to general awareness that dignity, autonomy, and respect are indispensable for meaningful life for all human beings, including frail older people and that even highly developed services must serve to support sensitively, not to be superior to them, or to exclude them.
- d) Strive to ensure that the aim of research is foremost life in old age and factors influencing its quality, not older people as research objects.
- e) Strive for lively connection between research and practice so that research and development respond to the needs of practice and their outcomes are appropriate for practice and are applicable;
- f) Introduce a mainstreaming of ageing into the arena of science, research and education, especially where it hasn't been explicitly present up until now, so that this perspective may expand knowledge and contribute to an improvement in the quality of life of seniors and their position in society (e.g. business/ trade, law, architecture, art).

D) Health institutions and systems:

- a) Be aware that the decline of health potential (hardiness, resilience, and adaptability) in old age bring with themselves specific health problems.
- b) A "geriatrization" of medicine requires more than increasing capacities in reaction to the higher prevalence of age-related diseases, more than some partial modification of diagnostic and treatment procedures or their availability without any age-discrimination. What is the issue is a deep transformation and evolution of medical thinking and education as well as development of the structure of health services.
- c) The association between health problems, disability and health-related quality of life and concrete diseases decreases with ageing. Mere interest in diagnosis and treatment of diseases often becomes inefficient, many times even harmful. It does not correspond to the variety of biological and also non-biological factors or to strong inter-individual variability of health and treatment priorities in frail and multi-morbid patients. It therefore needs to be complemented by the provision of qualified interest in other causal and clinical factors including functional difficulties which are multi-causally determined.
- d) Clinical aspects of geriatric frailty and multicausal geriatric syndromes (the geriatric giants) become priorities of geriatric medicine superceding the disease-model.
- e) It is essential to sensitively subordinate medical decision making and diagnostic, treatment, nursing and other medical stereotypes to existential aspects, including quality of life, autonomy, and improving the social roles of frail older people.

- f) We urgently draw attention to the fact that the health problems of frail older people are often not rightly considered and acknowledged by doctors and other health workers and thus intervention is absent or inappropriate. Frail geriatric patients are still frequently perceived as an unpopular burden. They are marginalized, because the structure of health services and disciplines created for the needs of the younger population does not reflect their problems, demands and needs. They often find themselves in a „no-man’s land“ between the interests and competencies of traditional medical specialties.
- g) Such misunderstanding is especially dangerous in the initial phases of ill-health and functional decompensation amongst frail older people, because of the risk of delay. Qualified geriatric medicine and the development of geriatrics as a discipline thus should not be identified only with long-term or post-acute care but should also be available in the acute phases of disease and during hospitalization, if acute care of other specialty is not necessary. It is an analogous requirement and necessity to the previous establishment of pediatric medicine.
- h) We call attention to the persistent risk of geriatric hospitalisation (hospitalism), the iatrogenic harm to older people including derogation of their dignity, the mistreatment of delirium, the inducement of immobility or inappropriate use of restraints in hospitals and nursing homes.
- i) We draw attention to hazards (risks) in diagnostic interventions, which are motivated not by the benefit of patient, but the purposeless or an alibiotic quest for hypothetical disease. We call attention to hazardous indigested polypragmasia and its role in the causation of multi-causal geriatric syndromes as well as to insufficient use of non-pharmacological interventions such as physiotherapy, ergotherapy, psychotherapy, home care and social interventions.
- j) We require that clinical decision making in geriatric patients is strictly based upon individual goals and aspirations, on identification and intervention (of) all treatable biological as well as other factors, rather than on diagnosis, treatment and prevention of specific diseases.
- k) We call attention to the need for sufficient capacity of qualified comprehensive mobile palliative care support to enable dignified deaths for older people in their familiar environments.

E) Seniors:

- a) Cultivate and express the will to meaning and to your unique individuality, strive for personal development, productivity, self-realization, and social participation at every age and notwithstanding possible disabilities and handicaps
- b) Do not give up if you suffer from a worsening of functioning and your health-related quality of life with advancing age – ask for qualified geriatric assessment and intervention for your health difficulties and ask for qualified geriatric medicine.
- c) Ask your local authorities for comprehensive services and support of long-term care in your community.
- d) Do not resign (reconcile) yourself to manifestations of age discrimination, to the non respect for your dignity, and even less so to mistreatment, abuse, neglect, or even domestic or institutional violence. Participate actively in solving the phenomenon of EDAN (Elder Dignity Abuse and Neglect) - „be the change, you wish to see in your life and neighborhood.“