The ethics of elderly care – is the Church prepared for challenges and opportunities?

Prof. Laetus O.K. Lategan
Professor: Research Education and Postgraduate Development
Central University of Technology, Free State
llategan@cut.ac.za

Abstract

This paper identifies applied ethics guidelines for elderly care that can be used by the church. The elderly community is a vulnerable community evidenced by healthcare, economy and social relationships. The elderly community is challenged by the COVID-19 pandemic, ageism, Fourth Industrial Revolution and social concerns such as abuse and becoming parents to grandchildren. Applied ethical guidelines have been identified to deal with the elderly community. These guidelines are (a) respecting their vulnerability and fragility, (b) protecting their lives from abuse and neglect, and upholding dignity, (c) securing a safe environment to live in and (d) providing quality access to healthcare and provision. These guidelines are presented to the church to use in its pastoral care of the elderly and to advocate care for the elderly community as part of a social contract between society and the elderly.

Opsomming

Die etiek van ouer mense versorging – is die kerk voorbereid vir die uitdagings en geleenthede?

Hierdie artikel identifiseer toegepaste etiese riglyne vir die versorging van ouer mense wat deur die kerk gebruik kan word. Die ouer mense gemeenskap is 'n brose gemeenskap soos dit duidelik blyk uit gesondheidsorg, ekonomie en sosiale verhoudings. Die COVID-19 pandemie, veroudering, die Vierde Industriële Revolusie en sosiale uitdagings soos mishandeling en om "ouers" vir kleinkinders te word, is uitdagings wat bejaarde mense beleef. Toegepaste etiese riglyne wat vir die versorging van ouer mense mense geïdentifiseer is, sluit die volgende in: (a) respek vir hulle broosheid en kwesbaarhied, (b) beskerming teen mishandeling en verwaarlosing en die volhou van hulle waardigheid, (c) voorsiening van 'n veilige leefomgewing en (d) gehalte toegang tot gesondheidsorg en voorsiening. Hierdie riglyne word aan die kerk gebied om in die pastorale versorging van ouer mense te gebruik. Die riglyne kan ook gebruik word om die versorging van ouer mense te bevorder as deel van die sosiale kontrak tussen die gemeenskap en ouer mense.

Keywords:

Ageism, COVID-19, ethics, applied ethics, vulnerability

Sleutelwoorde:

Veroudering, COVID-19, etiek, toegepaste etiek en broosheid

1. Orientation

The Coronavirus disease (COVID-19), caused by the severe acute respiratory syndrome Coronavirus-2 (SARS-CoV-2), cannot be ignored in the discussion on vulnerability as the current pandemic is contributing to increased economic, healthcare and emotional vulnerability.

With the breakout of the pandemic, it was projected that 50% of people dying from COVID-19 would be older than 80 years (World Health Organization [WHO], 2020a; 2020b). The morbidity points primarily towards elderly people.

This pandemic again draws attention to an unresolved question: that of saving lives in the context of limited healthcare resources. This question is not new as health economists have raised the question before: on whom should the available budget be spent? Must it be spent on people who *can* contribute to the economy, or people who *have* contributed to the economy? The elderly community is core to this debate. A stark reality of South African healthcare are the triple endemic challenges resulting from lack of access, high cost of healthcare services and poor outcome of the healthcare services (Republic of South Africa [RSA], 2020a:110).

In newspaper columns in 2020, Annemans (2020a), reflected on what can be expected from the emerging pandemic. He raised the question on the ethical justification of closing an economy to save lives. His commentaries are sober by acknowledging that the uncertainty of the disease called for drastic measures although an operative economy is also required to secure healthy living. The key argument is that as the cost of human life cannot be calculated so can the importance of a functional economy not be ignored. It cannot be overlooked that the pandemic caught societies off guard as societies where not sure how to deal with the anticipated effects of the pandemic (Annemans, 2020b). Annemans (2020c) is therefore provocative in his view that there should be a total societal transformation, driven by digitalisation and new social cohesion, to really make the world a better place to live in. From his comments it is evident that the pandemic contributed to vulnerability but also the opportunity to change the social order of society.

In the early days of the COVID-19 pandemic the WHO (2020c) commented that "… older people face significant risk of developing severe illness if they contract the disease due to physiological changes that come with ageing and potential underlying health conditions."

The elderly community's challenges are not limited to healthcare services and delivery only. The associated lockdown restrictions under the national state of disaster announced by President Cyril Ramaphosa on 15 March 2020, restricted elderly people from moving out of geriatric institutions during Lockdown Level 5 (March – May 2020) and Level 4 (May – June 2020). Restriction of movement and social interaction as part of human behaviour both have survival as motive but due to the pandemic have become opposing objectives. The elderly community is again subjected to the challenges caused by the pandemic.

For the church community is the obvious question if the church is ready to deal with an elderly community in the wake of the COVID-19 pandemic. How does the church deal with existence challenges of the elderly amidst

the reshaping of society to accommodate what is now commonly known as the "new normal"? The Collegeville Institute (2015) comments that religious traditions have a fundamental role to play to guide people in understanding humanity, the meaning of existence and to live and how to die well. This is especially evident in a time of crisis such as during the pandemic. Through elderly people the church can also focus on Christ's compassion with all people, ages and health conditions (Baloyi, 2015:6). Koenig (2020) confirms the important role that "religious faith" plays in the life of elderly people, especially during a time of stress such as the pandemic. Domingues (2021) shares the Brazilian Catholic Church's outreach to the elderly community during a time when physical contact was restricted. This, however, did not restrict engagement with the elderly community as this is a basic need expressed by this community.

This study wants to address this question on the readiness of the church to deal with the ethical challenges associated with elderly care. The outcome of this study is to present ethics guidelines that can be used to engage with elderly people and to make decisions concerning their well-being. The approach taken in this study is to promote ethics guidelines for elderly care within an applied ethics framework.

Before the ethics guidelines can be presented, challenges facing a growing elderly community apart from COVID-19 should be considered.

Although the context of application is South Africa, the global context on ageism cannot be ignored as a growing aging community is not limited to South Africa. In addition, the ethics of elderly care is a global need. This need has been sparked by Chan (2017:113) that the WHO moved the health needs of the elderly from the "back burner" to the "full heat of attention". South Africa is also in need of an ethics for the elderly. The absence of public health ethics framework for the geriatric community from a South African perspective is confirmed by Lategan (2021) in a study on this topic. The same can be observed for the church in South Africa as confirmed by a database such as the Sabinet African Journal Collection. An ethics of elderly and care or aspects relevant to elderly care are either not discussed in detail or not viewed from the latest developments in old age care or ageism as reported by, amongst other the WHO.

2. Challenges facing the elderly community

The elderly community is growing which will unavoidable present challenges that cannot be ignored.

The WHO's *World Report on Ageing and Health* (2015), a Newsletter on Ageing and Health (2018a), Report on *Integrated care for older people (ICOPE) implementation framework: guidance for systems and services* (WHO, 2019) and *Decade of healthy ageing: baseline report* (WHO, 2020d) suggest that the world population older than 60 years will nearly double by 2050. *Ageing is labelled as a global phenomenon*.

The 2020 South African Mid-year Population Estimates Report approximates the people older than 60 years to be 9.1% of the population. This Report states that the population 60 years and above increased by 1.9 million people from 2002 to 2020. This growth represents an increase of 1,1% for the period 2002 to 2003, and 3,0% for the period 2019 to 2020 (Republic of South Africa [RSA], 2020a:10,12). The report identifies the apparent vulnerabilities in the age group 60 years and older caused by the need for social assistance programmes, easy access to cash transfers, food programmes and healthcare. The situation is not improving due to the COVID-19 pandemic (RSA, 2020b). Older people are at a higher risk of being infected by the Coronavirus because of physiological changes and underlying health conditions associated with ageing. This is true because of geriatric syndromes which are more common with elderly people than other age groups.

The Sustainable Development Goals (SDG) Country Report in 2019 estimated that 71.9% of elderly people received an old-age pension by 2015. This pension is one of the social grants of the Bill of Rights in the Constitution, highlighting the socio-economic rights of South African people (RSA, 2019:26). The high percentage of old-age pension awards is an indication of the geriatric community's (financial) vulnerability. Furthermore, the 2019 novel coronavirus (COVID-19) pandemic confirmed the fragility of the elderly. Hence a call was made to protect the elderly in more than just their health (RSA, 2020b).

In a report from the WHO (2021), the challenges of *ageism* were identified. It was stated that it has consequences for people's health and well-being. This is based on declining physical and mental health, greater than before social remoteness and loneliness, escalating financial insecurity, decreased quality of life and premature death.

The elderly community is further challenged through *dementia* (WHO, 2012) and the raising need of *palliative care* (WHO, 2018b).

Given the comments in sections 1 (COVID-19 and affordability of [elderly] people's healthcare) and 2 (ageism), an obvious error is to limit the need of the elderly community to the matters of ill health, death and dying only. The following motivation is presented for this claim:

- Firstly, there are various age categories of elderly people and hence are their needs not the same. Although there are differences in the way that old people are categorised, the chronological age of 65 years is normally considered as index for being a person of age. Mitchell (2013:481) refers to the "older adult" to accommodate a variety of life spans. It is widely accepted that retirement, financial sustainability and social interaction impact on the elderly person (cf. Baloyi, 2015; Lategan, 2017 & Theron, 2014).
- Secondly, the concept of healthy aging is promoted. Healthy ageing is defined as "the process of developing and maintaining functional ability that enables well-being in older age" (WHO, 2015:28). The focus on healthy ageing is through raising awareness of inequalities, importance of social determinants and the continuous improvement of health equity. Age cannot be the only deciding factor to determine the needs of the elderly community.
- Thirdly, is end-of-life care not only about death and dying as this is the care focusing on the last stage of life which is much broader than death (Lategan, 2020:71). End-of-life is also not to be confused with palliative care. Palliative care supposes no activity to prolong life but rather to comfort the person. Palliative care can be regarded as an extension of the obligation to protect life although it has a different objective (Lategan, 2020:73).
- Fourthly, is the growing phenomenon of a grandparent becoming a substantial parent to a grandchild. Apart from advantages to transfer family values from one generation to the next (Abdullah, 2020), there is also a challenge when grandparents are not the supplementary parent (co-parenting) but the substantial parent. Although the value adding experience of co-parenting cannot be ignored, the generation gap cannot be overlooked either (Lunga, 2009:85). Apart from relational challenges, physical, emotional, financial and social difficulties are also recorded. This becomes more apparent when the elderly experiences weak health, live in poverty, has to deal with grandchild's pregnancy or subsistence

addiction (Lunga, 2009:82-85) or uses own livelihood to care for other (Baloyi, 2015:5).

- Fifthly, elderly abuse is widespread reported. The American National Center on Elder Abuse (ANCE) (2021) identifies seven types of elder abuse: physical abuse, sexual abuse, emotional abuse, financial and material exploitation, neglect, abandonment, and self-neglect. Kotzè (2018) mentions that elder abuse is a global public health, human rights, and criminal justice problem. She continues to say that elderly abuse is evident in all socio-economic groups, provinces and cultures. Theron (2014) refers to this reality as that people in their golden years are treated like "waste". Although there are many reasons attributed to elderly abuse, socio-economic circumstances take a leading role in this matter. Baloyi (2015:6) adds her comment by saying that elderly abuse is also evident in the neglect of providing food, accommodation, clothing, comfort and hygiene.

From these comments it is evident that elderly people are challenged by physical, emotional, personal, religious, and environmental issues, as confirmed by Nunes (2015:233-234), Fleßa and Lueke (2020:20-22) and Koenig (2020). Etienne and Warner (2015:26) refer to the social determinants of health that are the "structural determinants and conditions in which people are born, grow, live, work and age". It is within these circumstances that the church should engage with the elderly community.

Although it can be accepted that some attention is given to the elderly in the context of pastoral care, scientific evidence on how the church engages with elderly care is a neglected research topic in South African theological discource (Lategan, 2017a). It should be noted that discusions in disciplines such as medical and bioethics can inform pastoral care to understand the complexity of elderly care. It should also be emphasised that this care includes end of life care (as the last stage of a person's life) but is not limited to this care only (Lategan, 2020).

A matter that is not yet fully unpacked and considered, is the growing reality of the Fourth Industrial Revolution (4IR) on the elderly community. In the Report of the Presidential Commission on the Fourth Industrial Revolution (RSA, 2020c) the following semantic claims are presented for the 4IR as defined by this Commission:

> *The 4th Industrial Revolution is an era where people are using smart, connected and converged Cyber, Physical and Biological systems and smart business models to define and reshape the social, economic and political spheres* (RSA, 2020c:23).

By using different algorithms and high computational capacity and capability more meaningful information is developed. Technologies that are driving 4IR are blockchain, artificial intelligence (AI), biotechnology, nanotechnology, cloud computing, internet of things, 3D printing and autonomous vehicles (RSA, 2020c:23). Although there are huge benefits for healthcare the unfamiliarity with these technologies is a threat to elderly people. Benefits include expanded access and fairness of human services (RSA, 2020c:34), multidisciplinary and multi-institutional collaboration to secure solution-based research resulting in appropriate medicine development (RSA, 2020c:36), human benefit as a result of improved healthcare services and smart healthcare (RSA, 2020c:41), analysis and data contribute to good planning, logistics and drug provision. These benefits will reduce expenditure and contribute to cost saving and expected value adding of R37 billion (RSA, 2020c:111). Another positive outcome is growing life expectancy. Improved life expectancy will contribute towards a growing elderly community and therefore a bigger segment of society. This will in return have implications for old age pension and care (RSA, 2020c:69). One more benefit is telemedicine that will use audio and visual technology to connect patients and healthcare providers. Through this connection remote diagnosis and preventative care can be provided. Accessible intelligence can also contribute towards saving lives. This can add R101 billion in value (RSA, 2020c:110). Due to people living in under serviced areas or unfamiliarity with technology, the benefits of the 4IR may not be experienced by the elderly community.

From these observations, it can be claimed that the current pandemic is not only challenging the well-being of the elderly community but raised again the affordability of healthcare for the elderly. The elderly community's ongoing growth resulted in ageism which requires a multi-focused approach to elderly care. Growing dementia and subsequent rising need for palliative care are adding to the special needs of an elderly community. The situation is further complicated by the emerging 4IR which uses technology to deliver on services. The unfamiliarity of 4IR technologies complicate social transformation and cohesion for the elderly community. Technologies associated with 4IR may be unknown to the elderly community but have the potential to reduce the elderly community to objects only. This reduction is linked to a replacement culture namely that if a something (read life) is not good enough it can be replaced (read ignored, leave behind). It would be a limitation of the impact of 4IR if it is viewed as a way to minimize social isolation only.

These observations confirm the vulnerability of the elderly community. Schröder-Butterfill and Marianti (2006) looked at the development of the concept vulnerability. It originated from the environmental sciences and

focused on the *impact* of *natural disasters* on humans. The impact is confirmed through disruptions and harm. Structural dimensions of disruptions and harm cannot be separated from social influence (2006:10). Vulnerability is therefore contextual and person-base. This is represented by words such as for 'poor', 'dependent', 'frail' or 'isolated' (2006:10). This calls on an ethics ecosystem when dealing with vulnerability. In this approach two perspectives are required: [context of elderly community] and [human experience of the elderly community].

Given the intention of this study namely to provide ethics guidelines to engage with elderly people and to make subsequent decisions with regard to their care, the obvious question is what kind of ethics approach is available to address the vulnerability of the elderly community within the context of the COVID-19 pandemic, ageism, healthcare services and human reduction. To this vulnerability can the economic dependency of elderly people be added given the high percentage of South African elderly depending on elderly social grants (cf. comment above).

A first response to the above question is to look into the broad-based understanding of what ethics is.

3. Highlights from the debate on ethics relevant to elderly care

The word "ethics" derives from the Greek word ήθος = "ethos" meaning habit or morals (Newman, 1971:80). This concept refers to a set of beliefs or ideas on what the accepted behaviour is towards other people, society, structures, and nature. The Latin word for ethics is *moris* and refers to customs, norm or behaviours that are acceptable to society (Smuts, Bruwer & Van Stekelenburg 1992:54).

Carter, Kerridge, Sainsbury and Letts (2012:101) comment that ethics can be grouped into *meta-ethics* (dealing with foundational ethical questions), *normative ethics* (providing principles) and *applied ethics* (application to situation).

Alongside these groupings of ethics there are three schools of thought, namely *virtue ethics*, *consequential ethics,* and *duty ethics* (deontology). Virtue ethics is person-based and looks at the moral character of a person. Consequentialism judges a situation by the consequences or outcomes of a situation. Deontology is based on the actions (duties) within a situation (Mautner, 1997:180-181,593).

Within the ethics lexicon references such as *moral love* (Dooyeweerd, 1984; Smit, 1985), *doing right*, *cause no harm* and *responsibility* are central features in ethical thinking (Douma, 1983; Velema, 1976).

The first dictum of ethics finds its origin in the comment not to do any harm. The reference in Latin "*primum non nocere*" or better known as "do no harm" is associated with Hippocrates' treatise on Epidemics (Retsas, 2019). In here Hippocrates advises to either help or do no harm to the patient. The emphasis is to do what is beneficial for a person.

Beauchamp and Childress's (2013, first published 1979) formulate respect for *beneficence, non-maleficence, autonomy,* and *justice* as principles for bioethics. These principles, however, are the backbone for ethics in health- and medical-related activities. In a seminal discussion initiated by Gillon (1994), the above principles were extended by adding "scope" to them. This recommendation has since then commonly been known as the "four principles plus scope" approach. Gillon argued that regardless of personal belief, orientation and affiliation, any person can commit to these principles. This addition by Gillon makes room for religious orientations and belief systems. After the English philosopher W.D. Ross, he referred to the four principles as *prima facie* principles, meaning that they are binding unless in conflict with another moral principle. "Scope" raised the concern of *if* and *how* these principles are applied and what their subsequent consequences could be. It can be argued that the principles identified by Beauchamp and Childress can be extended beyond health- and medical related activities as they are relevant for all ethics discussions. This comment will be further explored in paragraph 5 when ethics guidelines for the elderly community is presented.

From the comments presented above, it can be concluded that ethics identifies principles for a situation (normative ethics) and apply these principles to a situation which is known as values for a situation. The purpose of ethics is to guide a situation to avoid dilemmas that can originate from a situation or to address existing dilemmas in a situation. The affordability of healthcare for the elderly would be a good example. Ethics will identify the value of life at all stages. Care cannot be limited simply because of age or contribution to economic activity. Where limited resources are available, then ethics will argue in favour of fair distribution of healthcare resources in support of healthy aging.

Following on the comments on ethics, that is to avoid or address ethical dilemmas, some exploratory comments on applied ethics are attended to in the next paragraph.

4. Contours of applied ethics

Applied ethics takes its origin from business and healthcare where ethical principles were required to deal with the ethical challenges relevant to those professions and their activities. Literature suggests that applied ethics is relevant to political ethics, medical ethics, bioethics, social ethics, business ethics and environmental ethics.

The value of applied ethics is its contribution to the identification and application of ethical principles to a given situation or activity. This approach adds to an understanding of the context of application. Applied ethics' advantage is that it is more a process than a final product for ethical consideration (Beauchamp, 2005:11).

Applied ethics is also a social ethic as it concerns itself with communities or populations. The applied ethics approach will link the ethical principles for a community or population's health and well-being to the healthcare needs of a community or population.

As illustration of what applied ethics is, is a study by Nunes (2015:218-242) a good example. Nunes completed a summative study of twenty eight European Union (EU) and twelve other countries outside the EU's Bioethics and Ethics Councils' documents and opinions on ageing and elderly people. From her study, seven principles and bioethical elements were identified. These principles and elements are:

- respect for human dignity, regardless of the stage of life,
- recognition of the individual's unique situation in regard to ageing,
- freedom of one's decisions,
- acknowledgement of elderly people's vulnerabilities,
- ethical commitment and social responsibility in monitoring the elderly,
- no age discrimination, and
- guidance to attain integral good and quality of life.

These principles can now be applied to geriatric care. The application of these principles will be based on the duties that must be performed (deontology) and what the result of these applications are (consequentialism).

With this as background an applied ethics for the church to engage with the elderly can be identified.

5. An applied ethics for elderly care

A scoping review was followed for the identification of broad-based ethics guidelines for the elderly community. This study follows the approach suggested by Sucharew and Macaluso (2019:416-417) who suggest that a scoping review provides an overview of the available research evidence without producing a summative answer to the research question or evaluating the quality of the evidence. Applied to the focus of this study, it means that a scoping review will identify what is the available body of ethics guidelines for elderly care. The value of the type of review is that broad-based perspectives are provided.

From this review a multi-focused view of ethics guidelines for the elderly community was evident. The following guidelines relevant to the purpose of this study can be presented:

Firstly, the application of ethical principles should address the ethical dilemma but at the same time offer opportunities of *growth* accenting the ethical growth to the ideal situation (Burggraeve, 1997). Decisions are taken to address ethical dilemmas, hence there are situations of imperfection. The question is what is learnt from this situation and how can someone be supported to gain ethical intelligence to address ethical dilemmas in future? *Ethics should take you from where you are to where you ought to be*.

Secondly*,* ethics should deal with *vulnerability* to contribute to *social justice* (cf. Horn, 2015). The concept of vulnerability is often reserved for application to groups such as women and children, older people, handicapped persons and refugees. Vulnerability is also due to weak healthcare systems, lack of finances, lack of communication and lack of access to (and affordability of) healthcare. A changing society, value and belief system and life and world orientation can further contribute to vulnerability.

Thirdly*,* care ethics offered the opportunity to develop relations, roles and responsibilities when dealing with ethical matters. An important pointer is *engagement* with people and the situation. In healthcare, engagement understood as shared lived experiences, is often absent. Care ethics will assist in avoiding power relationships and domination. The challenge is to meet *respectfully* the care receiver in his/her context (Grypdonck, Vanlaere & Timmerman, 2018).

Fourthly*,* ethical challenges cannot be limited to the care receiver only but should also be extended to the caregiver (Vanlaere, Burggraeve & Lategan, 2019). This perspective is enriched by Glouberman and Mintzberg's (2001) four quadrant views on the world of health, namely *cure* (doctor), *care*

(nurses, therapists, general healthcare workers), *control* (managers) and *community* (support networks, pharmaceutical developers, technologists, and more) as they all contribute to offering a professional and quality service. This insight assisted in advocating the important role of medical humanities and coaching within healthcare. To this insight, professional ethics and integrity can also be linked.

Fifthly, ethics must be managed. This claim is based on the application of ethical protocols and decision making to improve the integrity of the situation. The question is what will be the outcome of the decision taken? There is a necessity to ask what the value is of applying ethical principles. *What difference will it make*?

Sixthly, ethics includes responsible decisions, as articulated by Badaracco (1998). He emphasises the difficult choices, based on personal values and commitments that the individual has to make. The outcomes of the decisions should be implemented.

Seventhly, applications of principles can result in new ethical challenges. As an example: the value of life is always regarded as an ethical principle. Hence, active euthanasia or euthanasia on request was declined. Assisted ending of life opened the debate on quality of life, own decision making and autonomy of personal decisions. Principles must be doable and implementable (De Wachter, 2013).

The broad-based ethical guidelines can now be rephrased as applied ethics.

6. Discussion

Typical of applied ethics is to identify the principles that can be associated with a particular discipline or profession. A literature review (Lategan, 2017a, 2017b; Vanlaere & Gastmans, 2010, 2011; Tadd, Vanlaere & Gastmans, 2010; Kasiram & Hölscher, 2015; Ludwick & Silva, 2003) identified ethical principles for elderly care. Relevant to elderly care are the following principles:

(a) respecting their vulnerability and fragility,
(b) protecting their lives from abuse and neglect, and upholding dignity,
(c) securing a safe environment to live in and
(d) providing quality access to healthcare and provision.

A first pointer from this discusison are the specific ethical principals for elderly care. These principles should serve as the basis of the church's engagement with the elderly.

A second pointer is that these principles resonate with the focus on *context* and *person-centredness* (cf. section 5). The importance of the empasis on the interrelatedness between person and context. The context of the elderly is unque as the conext contributes to the ethical challenges of the elderly.

A third pointer is that vulnerability and fragility (state of a person's health influenced by physical condition and social determinants) are the core to elderly care. This care calls on the protection of life.

A fourth pointer is an added interpretation to respect for life and goes beyond the limited interpretation of respect for and protection of life, that is to end a life. The respect for life demands a safe live environment (habitat) and requires quality healthcare services and delivery thereof.

These pointers contribute towards a baseline applied ethics for elderly care that can be used by the church in the care of the elderly. This focus can be illustrated through the following figure:

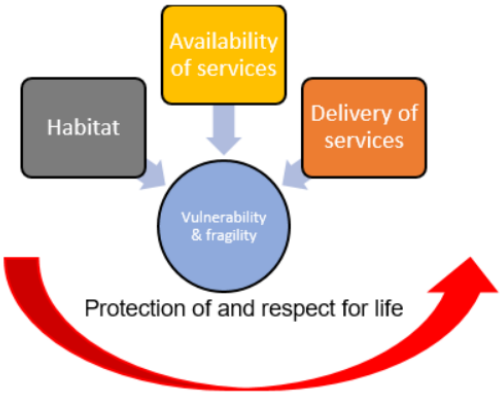

Figure 1: Applied ethics for elderly care

7. The relevance for the Church and her pastoral care

The church has a three-fold responsibility towards the elderly community. Within the context of this study the focus will be on ethics:

- Firstly, to identify what are the Biblical foundations informing an ethics for elderly care.
- Secondly, ethics in the pastoral care of elderly care.
- Thirdly, advocating ethical care of the elderly community to society.

These three-fold activities can be explained as follows:

Biblical foundations informing an ethics for elderly care

The Bible does not embody a different set of rules for elderly. Respect for life, dignity towards people, protection and care are demanded for all persons, regardless the stage of life. As the elderly is part of vulnerable groups they can be counted as part of the widow and orphan groups and can therefore call on the care for marginalised people.

The Biblical foundations contributing to the ethics for elderly people are anthropology, creation, redemption and calling.

- *Anthropology:* Health and well-being cannot be limited to safeguarding life only. Humanity is much more than the preservation of life. It is also about living a meaningful life. The balance is therefore found in respecting life but living it respectful too. This calls on a broader understanding of life, its functionality and meaning as only a biological function.
- *Creation:* The development of a liveable environment is not limited to the physical space (habitat) only, but what contributes to a liveable habitat. To this can be added what informs a sustainable life. Livelihood, sanitation, recreation, food, security and safety are commonly associated with quality of living. To quality of living can be added education, healthcare systems and economic systems. A view from creation confirms that life is protected by the physical and structural environments. These environments too should be developed and upheld to secure the value of life.
- *Calling:* Calling as a central part in a Christian lifestyle is about the totality of behaviour towards others and the self. This comment is built on the value of responsible and respectful behaviours towards other people, especially the vulnerable.
- *Redemption*: The Christian community lives in the wake of Christ redemption from a meaningless life as a Biblical promise. This expectation is part of the church's confession that life will end in its known physical format but the relationship and spiritual life in Christ are infinite. Redemption goes further than internal life but is conducive to change the world within which we life. With this orientation, hope is transforming our experience of life as we know it and inspires to bring right doing, justice and fairness to a fallen world.

The Biblical foundations above set the scene for the respect for life, protection from social, physical and financial abuse and care for the vulnerable elderly community.

Ethics in the pastoral care of the elderly community

Pastoral care is the faith-based care of the congregation. This care is provided based within the context of a lived experience within the church's Biblical interpretation, practice of the confession and established traditions. This experience is now challenged by the phenomena of late modernity, individualising of society, social inequality and the diminishing role and influence of the church as an institution. Late modernity suggests that the expectations of a modern society to group everything to secure success and stability were not accomplished. The society is now shaped by individual expectations and no longer groups and classes. The global economy emphasised the huge gaps between those that have and those that do not have. The church has no longer the influential status and voice it used to have. This requires a new reception of pastoral care (Gärtner, 2015:23-43).

Pastoral care for the elderly is still focusing primarily on the end-of-life matters. This study made it clear that there are more needs than matters of death and dying only. This observation is well captured by Dillen (2015:221-241) who correctly broadens this focus by commenting on the importance of bringing hope to people. For elderly people hope will be recovering of illness, be surrounded by family when one is passing on, attending to outstanding matters or to be part of a family member's wedding or birth. Christian hope is vested in God. Hope is also the basis to contribute to a changing world. An important feature is to link through hope the current reality with eschatology. Dillen promotes Arthur Lucas' result driven pastoral care know as "The Discipline". This approach, which is very much focused driven, is in particular relevant for the healthcare and social care sectors. The point of departure is hope and not the shortcomings and needs. Need (diagnosis) and action (support) are working concurrent in this model.

The ethical focus to the pastoral care for the elderly emphasises the way in which the pastor should interact with the elderly person: *with respect*. The respect should be presented in such a manner that human dignity is uphold and the context is shaped to make it as user-friendly and beneficial as possible. In return is the elderly person also sensitised to show respect for the network of people supporting the elderly. At the same time is the elderly also assisted to uphold an own dignity by participating in society as effective as possible.

Ethical care of the elderly community to society

From this study it was clear that the elderly is challenged by the pandemic resulting in healthcare, economic and social vulnerability; ageism caused by the growing elderly community; abuse, neglect, isolation and potential inability to become part of 4IR. The elderly's faith and church-based activities are further challenged by lockdown restrictions and an expected change in church services necessitated by the pandemic.

Dealing with an elderly community's needs cannot be limited to healthcare only. A multi-phased and multi-institutional approach are required to secure effective healthcare. In practice this means that the church (as a collective of faith-based institutions) should become part of the broader narrative to secure effective care for the elderly. In a study on the church's role in healthcare it was stated that the church should find its way in a changing healthcare environment influenced by technological development. The church should continue to contribute towards changing people's lives through her transformational message of re-creation and redemption (Lategan, 2017a).

The ethics guidelines in this study can be used as basis for the narrative and to establish a human rights culture for the elderly as a vulnerable community. The view of Raymaker's (2016:125-126) can be followed here. He emphasises the role of ethics in society based on the idea of a social contract. In the various nuances of the social contract the emphasis is not on material equality but formal equality. After Rawls he identifies the procedural justice and moral impartiality that should be practiced when dealing with (elderly) people. In practice this means that the personhood of the elderly should be promoted regardless gender, ethnicity, economic or social status or creed.

8. Summary

This study identifies the elderly community as a vulnerable community as a result of many reasons. Within the current COVID-19 pandemic is the pandemic itself with the associated lockdown rules, ageism because of a growing elderly community and new societal developments such as 4IR, contributing factors to the vulnerability and fragility of the growing elderly community. Social circumstances such as abuse, family structures and compromised healthcare and services are adding to the vulnerability of elderly people.

To address these challenges applied ethics guidelines were identified. These guidelines are:

a. respecting their vulnerability and fragility,
b. protecting their lives from abuse and neglect, and upholding dignity,
c. securing a safe environment to live in and
d. providing quality access to healthcare and provision.

These principles are useful for the church to identify what are the Biblical foundations informing an ethics for elderly care, ethics in the pastoral care of the elderly community and advocating ethical care of the elderly community to society.

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