Most clinicians who write about the aged begin with a section on the demography of aging. This practice is helpful because accessing the impressive global, national and local data about the aging brings the elderly to center stage and helps us see their faces. While the aging of the population is an international phenomenon, the number of elderly persons in Allegheny County is impressive and partially explains why the first annual Rita M. McGinley symposium is exploring social justice and the elderly. For more than two decades, Allegheny County, Pennsylvania has been home to one of the oldest populations in the United States (Schultz & Briem, 2009). While the folks in southwestern Pennsylvania are tough, as anyone familiar with the topography and weather patterns can testify, it is still surprising to learn that many of the nation’s elderly call Allegheny County, and in particular the city of Pittsburgh, home.

The demographic profile of the population of Allegheny County reflects the development of the suburbs, urban renewal around the rim of the city and in Old Allegheny, and the collapse of the steel industry. In the forties and fifties, young professionals and young families moved to the suburbs seeking to own homes and create the space and the life style that they desired for themselves and their children. Parents remained in the family homesteads; their children and grandchildren moved east to Monroeville or to the North and the South Hills. Downs (1976) notes the rapid growth of the suburbs is often associated with economic and social problems in the communities that the suburbanites left behind. In Pittsburgh, the growth of suburbia contributed to an interesting demographic profile: a concentration of older persons in the city of Pittsburgh and younger people in the suburbs. Another consequence of the flight to the suburbs and the urban redevelopment that took place in Pittsburgh in the sixties was the consolidation
of poor households, especially poor minority households, in the city. Today, many of the city’s elderly live in neighborhoods characterized by high crime rates, poor quality of schools, limited public and private services as transportation and grocery stores and an inadequate tax base to support essential human services.

Urban renewal and the movement of young families to the suburbs are common in many American cities. What is different, and unique to Southwestern Pennsylvania, is the sudden, dramatic population shift which followed the demise of the steel industry. When the steel mills began to close in Allegheny County and jobs were no longer readily available in the steel communities along the three rivers, young workers and their families left the area in search of work and a better life. Schultz & Briem (2009) estimate that in the early 1980’s this “age-selective annual out-migration peaked at over 50,000 people a year (p. 1).” Although understandable, the exodus depleted the community of human and economic resources and left behind parents and family members who could not or would not leave their homes. Some thirty years later, the demographic profile of the area continues to reflect this migration. Younger and middle aged steel workers, and those whose incomes were derived from the steel industry, who stayed in greater Pittsburgh, found jobs that provided less salary and fewer benefits. Steel workers, eligible for retirement, took their pensions and remained in the communities where they had lived for most of their lives. Without the incomes and security they once had, these workers and their spouses aged in place. The communities that once welcomed them as newly-weds and young families grew older. The number of elderly people living in older Pittsburgh communities, coupled with the migration of younger families during the forties, fifties, and sixties, but especially in the mid-eighties, has created an interesting
demographic mosaic: many older people and few young people. The age imbalance indicates that Pittsburgh and Allegheny County may face a future labor shortage if it fails to create economic opportunities appealing to a new cadre of young workers (Morrison, 2005).

The demography of the city along the three rivers has also created natural senior citizen villages. Today, 18 percent of the population of Pittsburgh is over 65; 30% of all area households have at least one senior member living there (Morrison, 2005); one in 6 residents in Allegheny County is over 65. Morrison (2005) using data from the University of Pittsburgh’s Center for Social and Urban Research, predicted that the peaks and valleys of the 65-84 year olds and the over 85 year olds in Allegheny County express and plot the need for new social and human services for the elderly in the county (p.2). The need for innovative social and human services to assist the senior population is another reason why the first annual Rita M. McGinley symposium addresses social justice and the aging.

The concentration of elders in neighborhoods has another consequence for families. Many children grow up without really knowing their older uncles, aunts, and grandparents. In Pittsburgh, except in the African-American communities, children no longer share the events of their days over cookies and milk with grandma. Older people are losing influence in their families and are not called upon for advice and help, especially in child rearing and family matters, because they are no longer in the neighborhoods where their children and grandchildren live.

The elderly in Allegheny County are home owners, voters, members of families, church goers, and important contributors to the life and landscape of greater Pittsburgh.
They are immigrants or first and second generation Americans. As has been observed, many of them are clustered as a single generation in city blocks or local neighborhoods. Anyone who has lived in older sections of the city, worked in senior centers, or visited the elderly in their homes can testify that Pittsburgh’s elders are independent, determined, and able to participate in communal life and the decisions which affect them and what they value. They are also vulnerable.

In discussing social justice and public health, Beauchamp (1976) cites a well known observation of Anthony Downs that intractable public concerns affect a small sector of the population and result from structures that provide benefits to the powerful and wealthy (p. 3). This reflection adds value to any public discourse about social justice and elderly persons, especially in the city of Pittsburgh. While persons 65 or older compose a relatively small part of the population of Allegheny County (16.8%), their access to services has been negatively affected by forced early retirement, housing and mortgage policies, zoning regulations, limited access to credit and insurance, and fixed incomes. While some elderly people would freely choose to stay in the “family house,” other are trapped there because they cannot afford to move or make their present homes safer, more comfortable, and more convenient.

The old neighborhoods of Pittsburgh, where the elders live, are not planned communities. Like Topsy, these neighborhoods developed. Old neighborhoods lack simple accommodations as benches along the street or covered areas to sit and wait for public transportation. There are fewer stores, sit-down restaurants, banks, markets, pharmacies, and parks, especially in the poor neighborhoods. Even churches, schools and
hospitals have closed, merged, and/or changed their names. Downs might ask why the older neighborhoods of Pittsburgh are so inhospitable to elders.

More significantly, what would it take for the new power elite in the city and in Allegheny County to look around; change their behavior; relinquish some of their control over policies; or even pay more taxes so that elderly persons can participate in and own the communities that they helped to build?

If safe housing and healthy eating are determinants of health, then economic and social policies which limit access to safe, affordable housing and proper nutrition are unfair because no one has the right to deprive another of his or her well being. Fixing up, or as we say, “redding up” broken neighborhoods and run down communities is not an act of charity; it is an expression of justice. It is a work that we are all called to do.

The social and ethical consequences of injustice are significant and far reaching. Failure to act justly affects everyone: the elderly who are left to live in less than healthy environments, and the rich, who are personally diminished by indifference, selfishness or greed. In the end, no one is happy or comfortable in a society where self interest is the dominant social value.

Another unintended outcome of the exodus of young families from Pittsburgh is that the elderly, who were left behind, seem to be more vulnerable especially in times of illness, death of a spouse, or some other catastrophic event. While vulnerability is a significant concept in European ethics and is recognized in the principles and declarations of the European Union, it is just beginning to be discussed by American ethicists (Dell’oro, 2006). What is more interesting is that our European colleagues do not think that vulnerability is a condition to be overcome, avoided or treated. They hold that each
of us, by reason of many circumstances, can be vulnerable. Vulnerability is part of being human. The 1998 Barcelona Declaration on Basic Ethical Principles in Bio-ethics and Bio-law, names vulnerability, autonomy, dignity, and integrity as the principles of bio-ethics and bio-law (Final Report, 1995-1998).

Vulnerability concerns integrity as a basic principle for respect for and protection of human and non-human life. It expresses the condition of all life as able to be hurt, wounded, or killed. It is not integrity, as completeness in any sense, but the integrity of life which must be respected and protected as vulnerable. Vulnerability….must be considered as a universal expression of the human condition. The idea of the protection of vulnerability can therefore create a bridge between moral strangers in a pluralistic society, and respect for vulnerability should be essential to policy making in the modern welfare state. However, vulnerability has been largely misunderstood in modern society as if all vulnerability, i.e. suffering, abnormality, and disability, should be eliminated in order to create perfect human beings. Respect for vulnerability is not a demand for perfect and immortal life, but recognition of the finitude of life, and in particular, the early suffering present in human beings (Final Report, 1995-1998, p. 5)

Different principles have shaped moral reasoning in the United States: autonomy, non-malfeasance, beneficence, and justice (Beaucamp & Childress, 2009). Called “principlism,” this ethical approach to understanding and addressing human behavior has influenced teaching and practice in schools of medicine and nursing for over 30 years. In the sixth edition, of their classic bioethics text, *Principles of Bio-medical Ethics,*
Beauchamp & Childress (2009) introduce a section on vulnerability in their discussion of protecting the rights of persons who are candidates for experimental treatment or who are invited to participate in research. However, unlike the Europeans, they do not include vulnerability as a fundamental ethical principle. Rather, in their limited discussion of vulnerability, Beauchamp & Childress refer the reader to the observation of Hume, that contiguity determines interest in and empathy for the other (Beauchamp & Childress, 2009, p.92; Norton & Norton, 2000, p. 318). Hume’s observation that isolation increases vulnerability seems to be more insightful in understanding the social circumstances of the elderly person in southwestern Pennsylvania than that offered by Beauchamp and Childress.

It seems that distance from relatives and friends increases the vulnerability of the aged, because lack of contiguity restricts the attention, expressions of kindness and signs of respect which the elderly person receives. At policy levels, isolation contributes to the distancing of elderly persons because their faces are absent when power brokers and policymakers gather. Separation also increases the chasm between the young and the old, an idea expressed in the adage, “out of sight is out of mind. Separation of elders from other members of the community perpetuates social and political climates that ignore and encourage neglect of the elderly. Hume also speaks about the negative consequences of defining the other as different from oneself (Norton & Norton, 2000). In the United States, the elderly are differentiated from the young, sometimes in hostile generational conflicts around the utilization of resources, especially in health. When the elderly, or any group, are conceptualized as other, they are treated differently.
Many Americans fear the aging process and seek to disguise it by coloring their hair, moisturizing their skin, and engaging in exercise to improve posture, balance, and mobility. Modifying or covering the physical signs of aging seems to convey a wish to hold at bay the loss of control and decision making associated with aging in this country. The youth oriented culture of the United States, unlike traditional cultures in Asia and Africa, does not afford places of respect, bestow important social roles, or give the elders places of honor in the family or in the community. The elder becomes “the other,” an observer rather than a participant in life’s events.

Nurses are recognized internationally for their concern and interest in under-served populations. Men and women choose nursing because they want to help people. Writers, who discuss vulnerability across the life cycle, name the young and the old as society’s most vulnerable people (Aday, 2001). Illness increases vulnerability and adds an extra burden for the young and the old. The ethos of the nursing profession also supports the humanistic inclinations of nurses and its students. Recent policy and educational statements urge members of the nursing profession to emphasize care of the aged in undergraduate and graduate programs of study. Foundations encourage and support curricular innovation through curriculum development grants and faculty fellowships in gerontological nursing. However, when the employment of nurses is studied, it appears, at first glance, that few nurses actually work with the elderly. This observation reflects the tradition of studying nurses’ employment by examining the settings where they practice rather than the populations that they serve. Even the recently released 2010 National Sample Survey of the RN population, reports that 5.3% of nurses practiced in extended or long term care settings; 10.5% worked in ambulatory care; 6.4%
worked in home health; 7.8% in community/public health and 60.2% were employed in hospitals (HRSA, 2010). These data support an erroneous conclusion that a small percentage of the 3.1 million nurses actually care for the elderly. The majority of elderly people who seek health care are in ambulatory centers, home care programs, or the nation’s hospitals. While hospitals are still recognized as acute care centers, the patient census has changed. In 2006, Medicare and Medicaid spent 500 billion dollars, to pay for 60% of the nation’s hospital bills (Government Paying, 2006). Contrary to the impression conveyed by national studies, nurses work primarily with elderly populations in hospitals and in ambulatory and home care settings. Yet the term geriatric nurse remains less attractive than critical care nurse. More schools of nursing offer courses in pediatric nursing than geriatric nursing. Courses on the care of the aged address healthy aging, the changes that accompany a normal aging process, and the signs, symptoms, and manifestation of illnesses in the aged population. However, undergraduates often meet the aged in nursing homes, rather than in their communities. So while optimal care of the elderly is usually framed as a multi-disciplined adventure, most programs of study in the health professions emphasize the contributions and the expected outcomes by discipline. Nursing is no exception. Aging is perceived to be an illness to be treated, not a stage of human development to be understood and enjoyed.

It is in the context of the first annual Rita M. McGinley symposium, that nurses and other health professionals are challenged to examine care of the elderly through the lens of social justice. During the symposium we will hear about dignity, respect for human life, association, participation, preference for the poor, solidarity, stewardship, subsidiarity, equality and the common good, themes that are central to the Catholic social
justice tradition (Byron, 1998). Interestingly, these concepts also form the infrastructure for establishing nurse-patient relationships. They are particularly meaningful for those who work with the elderly because age, illness, and isolation challenge human dignity and identity itself. Loss of dignity and self respect are manifested physically, socially, culturally, psychologically and spiritually. Carse (2006) observes that vulnerability can cause a “paradoxical relationship to the body” (p. 37). In these situations, an illness or malady becomes so preoccupying that the personality and identity of the person fade into the background as the person becomes his/her pain, immobility, or loss.

Self-absorption creates difficulties at any age. It is particularly distressing when a beloved mother or grandmother loses interest in her family, the events of daily life and even her own appearance. It is sad to watch a once vibrant person become preoccupied with bodily functions or focus her energy and attention on objects or situations which are no longer under her control. Loss of identity, loss of self esteem, and diminished self actualization alienate the elderly person from herself, her family and friends and even from her care givers. Self-absorption leads to avoidance behaviors (limited association with others and unwillingness to participate in social events). Unrecognized, ignored, or explained away, feelings of loss and separation isolate and leave the older person alone with a diminished sense of dignity, identity, and self worth. For a nurse or health professional, whose practice is infused with the principles of social justice, the manifestation of feelings of alienation from self and others is a compelling cry for help and deliverance.

Carse (2006) says “the agony of isolation,” separates a person from those who could be of help (p.38). Pain, immobility, loss of balance and frailty restrict travel and
limit participation in social events and family outings. Self centeredness and self-absorption, the adoption of negative identities and low self esteem also contribute to the isolation of the elderly and lessen their sense of dignity and importance in the family and the community. In Pittsburgh, social, economic and geographical factors have contributed to both the physical and social isolation of the elderly.

The take home message of the first annual Rita M. McGinley symposium reminds health care workers, especially nurses and students of the health professions, to use the principles of social justice to inform their practices, model their interventions, and coordinate their activities.

What would the practice of nursing (I am using nursing to apply to all helping professions) look like if it reflected the principles of social justice: dignity, respect for human life, association, participation, preference for the poor, solidarity, stewardship, subsidiarity, equality, and the common good. In my opinion, the social justice principles can be best summarized in the principle, respect for human life. When a nurse values human life, she shows respect and reference for the other, in this case, her elderly clients. Standing in solidarity with the aged, the nurse looks into their faces, sees with their eyes, hears with their ears, and touches with their hands. She blends generosity and compassion, greeting elders by name, acknowledging their position within a family and community. She engages them in conversation and encourages them to relate to and join with others. She facilitates their involvement in decisions that affect them and what they value. Nurses, imbued with the social justice tradition, treat everyone, most especially their elderly clients, as equals or as wise superiors. Justice requires that no one play
power games with the elderly, seeking dominance over their elders because of position, authority, knowledge, or strength.

Recognizing the precious resources of the health care system, social justice requires that nurses and other health professionals help patients and families to conserve their resources, human and financial, and to use the health care commons wisely. Our elders can teach us how to use things and resources prudently. Older people do not live in a disposable society, abandon what works, or trade up.

Wise stewardship of health care goods expresses a commitment to the common good, another pillar in the social justice tradition. In *Pacem in Terris* (John XXIII (1963) reminds us that the common good is sustained when the rights and duties of each member of society are protected. Concern for this common good affirms that each of us grows or is diminished with the other. Christian justice recognizes that some people need more than others, but always insists that the just person’s decisions show a preferential option for the poor and less fortunate. The just person looks into the face of the elderly and acts to protect his interests. Justice is more than fairness.

Solidarity (being with, feeling empathy and compassion, walking in the elder’s shoes) undergirds association or participation. Practically this means, spending time with the elderly, being patient as the elderly person makes decisions about his life or his care; giving the elderly person as much support and information as he desires; creating with him activities and events that interest and please him and are of value to him; encouraging him to reach out to others; seeking his involvement in family and communal events and decisions; and respecting his opinions and advice.
Subsidiarity expresses the idea that the best decisions are made by the person who is closest to the problem and most likely to be affected by a decisional outcome. Although decisions made by nurses and other health team members in chart rooms or by adult children in their homes are neat and expedient, they may not meet the high standard of social justice.

Health professionals can use insights gleaned from the social justice tradition in their engagement with the health care team, collaborating and actively participating in the co-ordination of care. Working co-operatively with others stewards health care resources and conserves the energy and time of aging persons and their families.

Perhaps Carse’s (2006) most interesting insight about vulnerability is the relationship she posits between vulnerability and the capacity to thrive (Carse, 2006). Noting that the ability to thrive can be jeopardized by vulnerability, she argues that the act of thriving itself requires that people be “vulnerable, open, receptive, flexible and tender (p. 35).” Associating with the elderly, coming to know them, listening attentively to their life stories, asking their advice, and respecting their decisions are ways in which nurses and other health professions integrate social justice into their practice.

Exploring social justice in the face of the elderly affirms the dignity of the elder and offers nurses and other health professionals the opportunity to thrive. In experiencing the wisdom of old age, the nurse or health professional sees as if in a mirror, her own face.
References


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