Bridging the Expectations and Reality Gap? Formal Caregivers' Views on Challenges in Dementia Care.

A Dissertation
Submitted to Adam Mickiewicz University
Graduate Faculty of the Social Sciences
in Partial Fulfillment of the
Requirements for the Degree of
DOCTOR OF PHILOSOPHY

By

Lilia Rosenfeld

Supervisor: Prof. UAM dr hab Jakub Isański

Poznan, Poland
November, 2024

Table of Contents:

List of Figures:

Introduction:

In modern Western societies, the aging population is increasing, leading to a greater prevalence of elderly individuals with dementia and other age-based diseases and challenges. By 2030, 1 in 6 people in the world will be aged 60 years or over. During this time, the share of the population aged 60 years and over will increase from 1 billion in 2020 to 1.4 billion. By 2050, the world’s population of people aged 60 years and older will have doubled (2.1 billion). The number of persons aged 80 years or older is expected to triple between 2020 and 2050 to reach 426 million. As a result, the demand for formal caregivers who provide professional care and support to these individuals is also rising. The quality of care provided to the elderly with dementia is of paramount importance to ensure their well-being and overall quality of life.

This introduction aims to explore the attitudes of formal caregivers towards the quality of care received by the elderly with dementia in modern Western societies. Understanding the perspectives and attitudes of these caregivers is vital for identifying potential areas of improvement and implementing effective strategies to enhance the overall quality of care.

Formal caregivers play a crucial role in the lives of individuals with dementia, providing a range of services including assistance with daily activities, medication management, emotional support, and ensuring a safe environment. Their attitudes towards the quality of care can significantly impact the well-being and experiences of the elderly with dementia.

Several factors influence the attitudes of formal caregivers toward the quality of care. These factors encompass various aspects such as the caregiver's training and education, workload, job satisfaction, available resources, and societal support. Moreover, the caregiver's perception of their role and responsibilities in providing care to individuals with dementia also plays a significant role in shaping their attitudes.

Research suggests that positive attitudes of formal caregivers are associated with better quality of care and improved outcomes for the elderly with dementia. Conversely, negative attitudes can lead to suboptimal care, increased stress levels, and diminished well-being of both the caregiver and the care recipient.

Considering the importance of formal caregivers' attitudes towards the quality of care, this research aims to explore the following aspects:

1. Identifying the prevailing attitudes of formal caregivers towards the quality of care provided to the elderly with dementia in modern Western societies.
2. Understanding the factors that influence these attitudes, including caregiver training, workload, job satisfaction, available resources, and societal support.
3. Assessing the impact of caregivers' attitudes on the overall quality of care received by the elderly with dementia.
4. Exploring potential strategies to improve formal caregivers' attitudes and subsequently enhance the quality of care for individuals with dementia.

By gaining insights into the attitudes of formal caregivers, policymakers, healthcare providers, and researchers can develop targeted interventions and implement supportive measures to promote positive attitudes and improve the quality of care for the elderly with dementia.

This study, conducted in Israel, examines the attitudes of care staff toward the quality of care provided to elderly individuals with dementia in modern Western societies. Its goal is to enhance understanding of this issue within the Israeli context. While Israel shares many cultural and social traits with Western countries, it also contends with unique challenges. By comparing Israel to other Western societies, the study seeks to identify common factors shaping staff perspectives on care, as well as those specific to Israel, such as its diverse demographic composition and distinctive healthcare system challenges. These findings aim to inform the development of targeted intervention strategies for Israel, while drawing on international best practices.

1. Specificity of dementia and the system of social support for patients and their families.

1.1. Etiology of dementia.

Dementia is a chronic disease, defined as the deterioration of an individual's intellectual capacity. Memory loss is the most common sign of this disease. Other mental functions may also be impaired, including judgment, the ability to concentrate, comprehension and orientation, learning abilities, mathematical and problem-solving abilities, behavior, and mood. Alongside memory loss, agitation, abstinence, seclusion, hallucination and lack of sleep commonly appear as well (Malak, et al., 2016; Atherton, et al., 2016). The most common cause of dementia is Alzheimer's disease. The disease was first described in 1906 by German researchers Alois Alzheimer and Emil Karpelin. Emil Karpelin (Emil Wilhelm Georg Karpelin) was a psychiatrist who made significant contributions to modern scientific psychiatry. Alongside Alois Alzheimer, a renowned neuropathologist and psychiatrist, he played a crucial role in identifying and characterizing what is now known as Alzheimer's disease. Alois Alzheimer is particularly recognized for documenting the first case of presenile dementia, a condition that has since come to bear his name. Early-onset Alzheimer's patients suffer from short-term memory loss, after which they develop a usually slow-progressing dementia. At this stage, the disease is difficult to detect. Memory loss is more apparent to family or friends than the loss of other functions. At a later stage, when the daily activities of the elderly, such as monitoring of financial matters, communication, self-care, and eating and drinking are impaired, the disease leaves no doubt in family members' minds that something is wrong. Disorientation regarding time and place, impaired judgment and concentration, aphasia, and speech impairment all appear later as the disease progresses. The most common risk factors for dementia are advanced age and a family history of the illness (Martin, et al., 2016; Goeman, et al.., 2016). Signs and symptoms of this disease have far-reaching consequences not only for a patient's nuclear family but for the healthcare system in Western society as a whole. This is due to the proportion of people suffering from dementia, accompanied by the aging of the general population. Thus, the number of patients with Alzheimer's, the most common type of dementia in the world, is expected to rise from 30.8 million in 2010 to over 106 million patients by 2050. This means that 1 in 85 adults will suffer from Alzheimer's Disease worldwide (Ginis, et al., 2017). According to data from the United States, there are currently 5 million elderly patients with dementia, and by 2050 the disease will have resulted in 1.6 million deaths (Teno, et al., 2016). Additionally, according to WHO data, by 2015, dementia was the seventh cause of death worldwide. It resulted in 1.54 million deaths, two times as many as in 2000. Thus, the death toll from future dementia is expected to increase significantly in parallel with the aging population and an increase in the proportion of elderly people in the global population. In Switzerland, for example, reports indicate that the death rate caused by dementia accounts for approximately 9% of total deaths per year (Martinsson, et al., 2018; Teno, et al., 2016). Furthermore, dementia is now the fourth most common cause of death in the developed world. According to academic findings, in a modern Western society, the number of institutions for the elderly will rise and most dementia patients will live out the remainder of their lives and die in an institution rather than in their own homes. Notably, the life span in these institutions is significantly higher in patients with dementia compared to the life span in institutions among the healthy elderly. That is to say, the burden on the healthcare system will increase significantly compared to today's expenditure, especially for older people with dementia who are more often patients in institutions (Moore, et al., 2017; Fleming, et al., 2017). Although the upward trend in the number of elderly people who end up in institutions is clear, the main obstacle to assessing this reality is the lack of concrete and accurate data from the field. Malak and her colleagues (2016) argue that the actual number of dementia patients is much higher than that presented by healthcare systems in Western society. In their opinion, this underestimation is due to the fact that most dementia patients are not diagnosed at all or only diagnosed at advanced stages of the disease.

This discrepancy in the data is because most elderly people with dementia live in their homes and are treated by family members until their illness reaches a terminal stage or even up until their death (Malak, et al., 2016; Lenox-Smith, et al., 2016). Researchers in Switzerland also report similar data. They report that more than 50% of 78,000 dementia patients live in their homes. Some of the elderly diagnosed with the illness live alone without family and care for themselves daily. The reality of elderly patients living at home, especially dementia patients, is considered more economical and cost-effective for healthcare systems, compared to care in institutions or hospitals. This data is not at all surprising; in advanced stages of dementia elderly people do not receive proper and appropriate responses to their needs, especially if they live alone with no help (Hansen, et al., 2017; Fleming, et al., 2017). Failure to diagnose dementia, lack of early identification of symptoms, lack of proper treatment for urgent illness conditions, and many other factors, have led in recent years, to a sharp rise in elderly dementia patients' need for emergency medical services as well as the number of deaths of patients hospitalized due to acute conditions that have not been correctly diagnosed (Fleming, et al., 2017). For example, among all applicants for emergency medical services in Canada, about 20-30% are elderly people with dementia. This number will grow significantly in the future (Martin, et al., 2016). Furthermore, in Western society, most elderly people who reach the final stage of the disease will die in institutions for elderly patients with dementia and not in their homes. This is a result of increasing demand for advanced medical services and the need for complex nursing care (Arcand, 2015). Other scientists agree with this claim as well. For example, US researchers have presented data showing that an intensive care unit is an ideal place to provide advanced medical services to the elderly population with urgent medical needs. That being said, among elderly patients with dementia, the benefits of such units have been decreasing significantly, alongside a sharp increase in financial expenditure. Hospitalization in these units has increased from 16.9% in 2000 to 38.5% in 2013.

Furthermore, the average period of hospitalization of a dementia patient in intensive care is also longer than it was before. This sharp increase in hospitalization periods for dementia patients in intensive care units is due to an increase in the rate of invasive artificial ventilation in this group of patients. For example, in 2000, for every thousand dementia patients, 39% underwent artificial ventilation, but in 2013, the rate of artificial ventilation was already 78% (Teno, et al., 2016). When assessing hospitalization costs for the elderly, it is important to start mapping out emergency medical care costs, especially when it comes to elderly people at the end of their lives, such as dementia patients. For example, spending on emergency medical services in England for the elderly at the end of their lives is estimated at £750 million (Fleming, et al., 2017). Other researchers also report high costs that are currently on a sharp incline as the population ages. Despite increasing awareness of the issue in healthcare systems around the world, there is currently no definitive estimate of accurate spending, due to underestimation of the number of elderly people with dementia (Fleming, et al., 2017; de Boer, et al., 2017).

Diagnosis

A mini-mental survey has been used to diagnose and detect dementia. The survey result of less than 24 points (out of 30) requires a more detailed cognitive and physical assessment. Additionally, it is necessary to rule out other treatable medical conditions. For example, depression, other psychiatric disorders, fever, Meningismus, Amnesia, and Wernicke-Korsakoff syndrome. Malak, et al., (2016) recommend not sticking only to the medical symptoms of dementia, but also mapping out all of the apparent signs and categorizing them. For example, hallucinations, confusion, posture, uncharacteristic and socially unacceptable behavior, falls and the traumas associated with them, muscular stiffness, and lack of control of bodily functions (urine and excrement) – are all medical symptoms. Decrease in self-esteem, lack of concentration, social isolation, memory loss, learning and instruction comprehension problems, lack of orientation, difficulty with problem-solving, decreased ability to calculate, language problems, and "loss of words" – are psychosocial and cognitive symptoms (Malak, et al., 2016; Arcand, 2015).

Austbo Holteng, et al, (2017) and her colleagues argue that alongside the mapping of medical and psychological symptoms, dysphagia, which is defined as a swallowing problem, should be emphasized. Approximately 93% of all patients with dementia suffer from swallowing problems from the onset of the disease, which intensify as it progresses. At the end of their lives, elderly people with dementia lose their ability to eat effectively on their own, endangering their lives through loss of weight. Additionally, swallowing problems that characterize all dementia patients result in life-threatening complications. These include aspiration and gastric content inhalation into the lungs, causing severe pneumonia, mechanical ventilation, and death accompanied by suffocation. Thus, a decline in end-of-life quality and an increase in mortality rates among dementia patients are direct results of dysphagia accompanying dementia (Austbo Holteng, et al., 2017).

The symptoms of Alzheimer's disease, one of the types of dementia, change according to the stages of the disease. Moreover, not every patient will suffer from the same symptoms. Furthermore, the duration of time that every phase of the disease takes changes from patient to patient. In the first stage of Alzheimer's, the patient does not experience memory problems and does not suffer from any deficiency. In addition, interviews with caregivers who are experienced in dealing with these patients indicate that it is not possible to notice dementia. However, already in the second stage of the disease, which is characterized by moderate cognitive decline, the patient suffers from the forgetting of single words or the presence of objects that are used daily. Yet a medical examination does not indicate unequivocal symptoms of the disease. In addition, family members, peers, and acquaintances often do not suspect a thing. When the disease progresses to the third stage, colleagues and family members begin to notice the difficulties the patient is dealing with due to moderate cognitive deterioration. Hence, already in a detailed interview with an experienced caregiver, it is easily possible to notice the memory problems and difficulties with concentration. In the next stage of the disease, the patient experiences forgetfulness of important events in his or her life and has great difficulty performing complex tasks, such as planning a dinner for the family and paying bills. In addition, in socially challenging situations such as the gathering of many people, a dementia patient becomes sad (sullen) and shows signs of restlessness. In the fifth stage of the disease, when the cognitive decline is defined as moderate to severe, which includes large gaps in memory and thinking, patients are unable to provide the address where they live or telephone numbers.

They are not oriented in time and place and make mistakes when they choose clothes appropriate for a particular event or season. In the sixth stage, when the patient suffers from severe cognitive decline and the forgetfulness continues to worsen, personality changes occur, which are manifested in suspicion of those around the patient and delusions. As this stage of the disease continues, patients need considerable help to carry out routine daily activities and later lose awareness of themselves and those around them and begin to suffer from extreme changes in sleep patterns. In addition, patients become incontinent. In the final stage of the disease, when the cognitive decline is defined as severe, patients lose the ability to have a conversation or even respond, although their ability to express individual words or paraphrases still exist (Leshko & Bugajska, 2018).

Treatment

There is currently no definitive single treatment for dementia. Most often the treatment is directed at symptoms, such as depression, sleeplessness, anxiety, underactive thyroid, etc. The direct medicinal treatment of the disease is limited. There are two major cholinesterase inhibitors approved for the treatment of Alzheimer's disease. These drugs cause an increase in acetylcholine levels in the brain. The first medication is Tetrahydroaminoacridine, prescribed as pills, with the dosage adjusted by the doctor. This drug improves the patient's function and reduces future deterioration. However, it should be noted that this medicine only affects some patients and causes side effects such as nausea, vomiting and diarrhea. As the drug dosage is increased, the side effects’ intensity increases as well. Additionally, treatment is not effective in the advanced stages of Alzheimer's disease. Another disadvantage of this drug is the potential for hepatotoxicity. This drug is also considered expensive. Another drug approved for Alzheimer's disease, Donazapril, is admitted orally and causes only a few side effects, but is also ineffective in advanced stages of the disease and effective only in some patients (Atherton, et al., 2016).

Although many studies have been conducted on this topic, there has been no progress in the field of drug therapy for treating dementia in over 20 years. Some studies show a significant decrease in the incidence and prevalence of the disease following certain activities that prevent its onset. One of the activities that give reason for hope is regular and consistent exercise over the years. With exercise, the onset of dementia is postponed for years - this is extremely important from an individual's point of view. For society too, a decline in the number of elderly people with dementia is a desirable development. Regular physical activity not only postpones the onset of illness for years but prevents death by maintaining better health (Grasset, et al., 2017). Other scholars agree with this claim. The lack of effective drug therapy in dementia encourages these patients’ caregivers to focus on seeking options for preventing the disease or preventing its deterioration. They believe that the sharp rise in dementia cases occurs not only as a result of the population aging but also due to lack of physical activity in older people. Thus, exercise becomes a desirable, relatively easy, and inexpensive solution for the system, since it appears that moderate exercise can curb the deterioration of the disease and even prevent it. This means that regular physical activity can reduce the incidence of the disease by 1.5 million cases in Western society. Furthermore, the performing of regular physical activity in a group of elderly patients with dementia ensures the cognitive and daily functioning of the elderly patients over time (Ginis, et al., 2017). The latest findings in the field are thus not at all surprising. Performing consistent physical activity results from both a cognitively and socially active lifestyle. Additionally, physical activity in itself raises the number of elderly people in good health and usually reduces the impact of chronic illnesses on daily life. This being said, the actual ability of exercise to prevent or at least postpone dementia still requires much research (Grasset, et al., 2017). So far, studies examining the ties between physical activity and dementia have been characterized by small participant groups, short and insufficient follow-up, and problematic research methods. Therefore, it is still impossible to assert that physical activity affects the incidence of dementia or its rate of progression. The lack of drug therapy that is effective at all stages of illness causes other solutions to be sought after. These solutions, such as exercise, are not at all universal (Atherton, et al., 2016). In approximately every decade, physical activity in the older population decreases by 10%, in addition to the reduction in the number of exercising adults. Today, people perform fewer and fewer physical tasks, and leisure time has also become quite passive (Ginis, et al., 2017). Additionally, in the terminal stages of dementia, physical activity or drug use is not effective at all. Dementia patients at the end of their lives need special and unique palliative care, which includes full-time nursing care. Today, there is a professional awareness of the need for supportive care for elderly people with dementia. At the same time, caregivers are unwilling to provide this service to patients with dementia, unlike palliative care for cancer patients or other patients with chronic illnesses. Medical caregivers cannot operate in this therapeutic arena based on evidence, since there is insufficient evidence in this area. The lack of a clear definition of goals and needs in supportive care for patients at a terminal stage of dementia not only prevents patients from receiving proper care at the end of their lives but also creates a sense of alienation and helplessness among family members. Furthermore, many difficulties are associated with identifying the end stage of dementia - duration of illness in different patients, medical decision-making by caregivers who do not know the patient personally - all these and other issues constitute obstacles to providing proper care for these patients (Arcand, 2015). Although there are differences in the identification of disease stages and differences in the course of the disease's progression among patients, there are several common areas related to these patients throughout treatment. Central among them is the consumption of food (feeding tube, comfort feeding), hydration (providing adequate fluids and preventing dehydration), breathing (reducing the risk of aspiration, prevention of pneumonia), pain management, life-end medicine (stopping blood tests and invasive treatments, and providing oxygen only if saturation is less than 90%, providing supportive medicine and comforting treatment) (Arcand, 2015). Austbo Holteng and her colleagues (2017) agree with this argument. They believe that palliative care among the elderly begins first and foremost with dysphagia. That is, proper feeding (oral only) and tolerant human contact are not only able to prevent pneumonia but also contribute to the quality of life of sick elderly people. According to these authors, food and meals are an important part of an individual's daily life and are a major source of enjoyment, providing quality of life for all people, especially for dementia patients (Austbo Holteng, et al., 2017).

Many researchers believe that managing pain in dementia patients is just as important as treating dysphagia, especially as the disease progresses, but the reality is quite different. Key findings in studies in Australia, Canada, Brazil and the United Kingdom report that pain management in these cases is sub-optimal and is characterized by limited evaluation, a lack of complete documentation, and long waiting times for dementia patients to receive pain relief intervention. The situation especially worsens when it comes to the advanced stages of the disease. At these stages, a cognitively impaired patient cannot ask for help and is unable to report the presence or intensity of pain. Poor management of pain in patients with dementia may lead to further deterioration in the patient's functional abilities, longer than usual rehabilitation, new sleep disorders, loss of appetite, immobility, and an increase in falls (Lichtner, et al., 2016; Fleming, et al., 2017).

It is important to note that sleeping disorders and sleeplessness characterize about 70% of dementia patients, and pain management as a one-dimensional therapy for the improvement of sleep is important but cannot solve a general problem with sleep among patients. Many symptoms of sleep disorders are dangerous to the health of the elderly with dementia and contribute to an increase in the mortality of these patients (Leshko & Bugajska, 2018).

As with sleep disorders, proper management of pain in dementia patients may reduce the rate of falls. However, it is important to remember that dementia patients tend to fall more than other adults. Falls have a highly destructive potential for the health and quality of life of dementia patients. About 27,000 American senior citizens die each year as a result of falls. The prevention of falls among dementia patients is the most effective treatment for the implications and complications that falls can cause (Leshko & Bugajska, 2018).

Despite the suboptimal treatment of many symptoms in dementia patients, the obvious drawback of contemporary therapy for dementia is the focus on strictly medical goals. The lack of a spiritual and emotional facet eliminates empathy, prevents sensitive and holistic treatment, and does not allow for the implementation of various other strategies, like music, exercise, and developing communication strategies. Testing of the effectiveness of these strategies, in addition to pharmaceuticals, is underway (Martin, et al., 2016; Murphy, et al., 2019).

Many researchers support the assertion that it is necessary to integrate additional methods of care, such as the use of music in addition to the medicinal treatments in use at present. Care through music (playing different musical works, a personal list of songs, musical activity) improves the psychological and behavioral indications of dementia. In other words, the use of music as an instrument of treatment continuously and consistently helps caregivers build communication with dementia patients even when they are suffering from an advanced stage of dementia. These findings are expected. The use of favorite and familiar songs for the elderly reduces anxiety and depression and elevates vitality, tranquility, and enjoyment that is so essential to a sense of well-being in life. In addition, music sharply reduces challenging behaviors on the part of dementia patients (such as violent outbursts against those around them). Furthermore, music evokes feelings from the past and thus brings up precious memories that have been forgotten. Even when patients are in the final stages of the disease, in which they lose verbal ability, they can connect to the rhythm of the music or hum to a song they know and love (Ekra & Dale, 2020). Music does not eliminate the multifaceted challenging behavior of dementia patients. It also does not eliminate the use of medications and physical restraints (such as ties to the bed). The use of music as a significant part of the care of these patients makes it possible to have a positive effect on moods and to reduce the necessary use of sedatives or physical restraints even within the framework of acute hospitalization of dementia patients. Thus, studies have found that playing music for dementia patients after orthopedic surgeries reduces confusion and delirium rates, and promotes relaxation that is expressed in the regulation of the heart rate, and a decrease in the number of breaths per minute (Cheong, et al., 2016).

Music is the cheapest existing treatment for the indications and symptoms of dementia. Its effectiveness in the face of budgetary investment exceeds all other treatments and interventions currently known in the field (Murphy, et al., 2019). Moreover, many caregivers experience pleasant feelings during the treatment, just like the patients. The playing of music and the production of good feelings among patients raise the sense of self-satisfaction among caregivers, due to involvement in a significant activity that shows positive results. Furthermore, playing music during the regular care of the elderly with dementia creates a positive routine in the institution and lessens the negative impact of a daily routine (Ekra & Dale, 2020). During acute hospitalization for different invasive interventions, music has the prominent ability to reduce pain and calm dementia patients who are recovering from anesthesia in a place they do not know. Music enables better communication and closer cooperation between dementia patients and nurses whom the patient does not know (Cheong, et al., 2016).

At the same time, alongside the many advantages of music therapy, there are also disadvantages. Music therapy is not universal. To increase its effectiveness, it should be planned well ahead of time and customized individually. It must be used methodically, consistently, and identically among the caregivers who play the music, as otherwise, the music becomes background noise that brings patients to psychomotor restlessness and causes harm. Every human being acquires musicality with their first breath and can respond to music in one way or another until the day they die. Admittedly, the mechanism of this effect is not known to this day, and therefore it is not possible to map all the effects of musical therapy. Conversely, care that integrates music shows better results than merely medicinal treatment (Cheong, et al., 2016). Incorrect use of music, like the incorrect use of any treatment instrument, may lead to deficient outcomes. Thus, dementia patients may respond negatively to music. For example, the elderly who suffer from profound depression become sadder. On the other hand, with the help of caregivers, relatives and family members it is possible to build a music list that will evoke more positive emotions (Ekra & Dale, 2020). In order not to put a further load on the caregivers' daily tasks, the many volunteers who are in institutions for the elderly can build the patients' lists (Murphy, et al., 2019).

One of the additional prominent barriers to the correct use of music is the position of many caregivers regarding music as entertainment and not as an effective instrument of treatment in the care of dementia patients. Caregivers minimize the value of music in the care of the elderly who have dementia and object to its use as a routine in daily care. In addition, caregivers express concern that the use of music will cause dementia patients to get up to dance and then the rate of falls among these elderly people will increase. However, this is only a hypothesis that has not been proven in the research studies existing until now. Nevertheless, like every intervention among these patients, on the part of the caregivers, increased alertness is required to prevent falls or other accidents during the movement of the elderly (Murphy, et al., 2019).

In addition, a research study carried out in Norway indicated that the care staff was found not to be sufficiently skilled in the deployment of this type of program. Therefore, there is a need to train accredited caregivers in music therapy so they can build a program that later on will be managed and maintained by regular caregivers who work with the patients. However, there is a fear that alongside many additional tasks, the care staff will find it difficult to assimilate music as a regular part of everyday care (Ekra & Dale, 2020). Another problem is the equipment for listening to music (such as I-Pads). These devices are small and get lost easily. According to researchers who have operated such programs, the disappearance of devices is a problem that has an easy and cheap solution. These devices can be safeguarded from being lost by using specialized facilities located near the patient. They are affordable, user-friendly, and durable, making them a practical solution for long-term use. (Murphy, et al., 2019).

Music is an essential part of the quality of life of caregivers and elderly people with dementia (Cheong, et al., 2016). The advantages of music that is integrated into the general care of dementia patients exceed the possible expenses and costs. Alongside the lack of effective medicinal treatment for dementia and the multiplicity of complications and side effects, the integration of music in care is essential to the quality of life of dementia patients in every stage of the illness (Murphy, et al., 2019).

1.2. Healthcare institutions for elderly people with dementia.

An institution that provides quality care for the elderly invests in five key areas: ensuring the quality of the overall care in the institution, a professional and skilled staff (allocating roles according to patient needs), preventing a patient's physical/environmental limitation (seeking alternatives for patient limitations - and there are many), smart management of patient records (establishing a clear and unique agenda, building work schedules for the patient), and health care safety (de Boer, et al., 2017). When comparing the quality of care provided to different patients, the base data of the institutions providing these services must be mapped out according to the different needs of patients. Institutions such as, for example, nursing homes, are given fewer resources and less skilled staff. In contrast, hospitals that provide services to cancer patients receive the best resources and high-quality developed infrastructures for a variety of medical and nursing services. The palliative service and the provision of a professional palliative care team require a wealth of resources. In Switzerland, for example, this is not only rare in many regions but accessibility to such services is limited for many patients. The patients who are most affected by this are dementia patients, who, in reality, do not receive this service at all. Additionally, the palliative care framework that is currently accepted in Western society is completely inappropriate for dementia patients. This is because the best palliative service for dementia patients is the one given in their natural environment, without moving them to an unfamiliar setting. Thus, a palliative framework for dementia patients does not exist in most Western societies (Martinsson, et al., 2018). The lack of a palliative framework for dementia patients increases the number of dementia patients who go through advanced stages of illness in institutions and shortens the time spent in these institutions from the day of admission to death. In other words, the inability of the family to give proper care to an elderly patient with dementia forces them to transfer the elderly person to an institution. As a result, inappropriate treatment at the institution results in the rapid development of complications that lead to death. Multiple neuropsychiatric symptoms, low cognitive ability and lack of independent daily function are aggravated by disease progression and are even more difficult to provide adequate treatment for in an institution (Lenox-Smith, et al., 2016).

Researchers from Poland extend the argument. They assert that living in an institution increases the risk of infections. Residents of institutions for the elderly are exposed to more than 1.5 million different contaminants a year. Every elderly resident in an institution is 5-10% more at risk of infectious diseases than an elderly person who lives in his or her home. The finding is not at all surprising: the poor quality of the institution’s environment, the crowdedness, the lack of isolation according to the medical situation, and the presence of drains and catheters without beneficial skilled medical care make the institution for the elderly a dangerous place (Leshko & Bugajska, 2018).

Today, common dementia care in most institutions comprises poor, low-level treatment that does not take into account the basic needs of these patients. Additionally, care providers in these institutions, most of whom are not professional caregivers, have not received the required training in the field of gerontology and lack the clinical skills required to care for the elderly (Pohontsch, et al., 2017). This, along with an increasing number of tasks, a lack of caregivers, and too many patients, as well as inappropriate wages, result in caregivers neglecting their duty to follow a professional code of ethics. For example, guidelines such as "just sit, listen and talk", "stay human", and "support patients in distress and even death" seem to be ignored (Pohontsch, et a., 2017, p. 6). It is easy to provide a supportive and relaxed environment that includes quality care with comfort feeding at an institution for the elderly when there are many tailored resources, but institutions for the elderly in modern Western countries are characterized by a lack of resources, a bleak reality in which dementia patients end their lives (Austbo Holteng, et al., 2017). Researchers from the Netherlands also see the situation in a similar way. In their opinion, a formal institution offers very basic services and is usually of poor quality. The formal institution does not allow for recognizing the person behind the dementia and his or her variety of needs. Additionally, the institutions that currently exist for the elderly in general and dementia patients in particular, do not guarantee quality of life and quality of care. Dementia patients are transferred to a formal institution to die in inhumane conditions, with many complications arising from prolonged bedrest combined with poor daily care. Thus, it is important to look for alternative frameworks to these formal institutions. One possible alternative to a formal institution is a "Green Farm" designed to provide care for the unique needs of each elderly person in small groups by a large professional team, under proper humane conditions (de Boer, et al., 2017).

Assessment of the nature of services in institutions for the elderly with dementia should begin with an understanding of the costs of services required in these institutions, and only then should their quality be assessed. Thus, it is first of all important to understand the level of complexity of the elderly patients' condition. The cost of treating a patient with a mild level of dementia is £26,000 a year; at a moderate to severe level the cost of patient care is about £ 43,000. For the remainder of a dementia patient's life, when dementia is defined as terminal, the cost of treatment is about £55,000. Researchers state that while costs have been taken into account in informal settings and even in-patient care, the real costs of treating a dementia patient are far higher than those presented in their work. Families are unable to provide care in their home covering all of the medical care the patient requires, due to lack of medical knowledge, high costs for medical services, and fear of social exposure. Additionally, of the known costs, approximately 16% (or £ 4.3 billion) of this sum for medical services is required for patient care, with general care taking place in the home or a private setting. About 44% (£ 11.6 billion) is a contribution from caregivers, family members and friends of these dementia patients - the treatment they provide free of charge or pay for. In England, some 670,000 people are estimated to be primary caregivers (without pay) for patients with dementia (Lenox-Smith, et al., 2016). It should be taken into account that further morbidity in dementia patients inevitably results in a significant increase in treatment expenses, especially when regular treatment of chronic diseases becomes a condition of exacerbating chronic illness. In patients with multiple chronic conditions, medications intended to manage these illnesses can sometimes cause harm to other bodily systems, leading to new complications.

Thus, treatment becomes more complex when invasive ventilation is needed. Despite high mortality rates, which reached 82% in the first year after mechanical ventilation, the cost of treating dementia patients with mechanical ventilation reached $95.3 million in 2013. This cost is significantly higher among elderly patients with dementia than in other elderly people. The low medical benefit of mechanical ventilation among dementia patients, along with the high cost of the procedure, is forcing caregivers to reconsider providing invasive medical services to elderly patients with dementia. Addressing the uncertainty as to the benefits, along with the high costs of medical services, raises many moral questions for policymakers. One of these questions is whether is it ethical to initiate and prolong the suffering of dementia patients at the expense of their quality of life (Teno, et al., 2016). Other researchers agree with the claim that mechanical ventilation adds suffering to dementia patients and their family members, although they believe that suffering associated with breathing should be considered alongside that of respiratory failure and choking. According to Lagu and her colleagues (2016), shortness of breath without medical intervention causes immediate death and, in many caregivers', opinions cause much more suffering to patients and those around them, than invasive ventilation. Additionally, despite added morbidity for dementia patients, early mechanical ventilation in patients hospitalized for acute conditions lowers the immediate mortality rate of dementia patients, shortens hospitalization, and significantly reduces its cost (Lagu, et al., 2016). So, the questions are: should we artificially ventilate or should we not artificially ventilate? Should we choose an intrusive intervention or avoid it? Approximately 96% of all dementia patient guardians and caregivers see quality of life as a primary goal in treating these patients. In reality, treating dementia patients instead of emphasizing comfort prolongs suffering while eliminating the patients' quality of life (Teno, et al., 2016). To achieve quality care in elderly care institutions for dementia patients, common requirements and standards must be established for all caregivers, who should follow specific guidelines for all those caring for the elderly. Differences in policies between institutions regarding end-of-life cultural values result in differences in therapeutic standards. One notable example of this is the communication between caregivers and patients and their families regarding the decision to refuse artificial resuscitation/ventilation - DNR (Do Not Resuscitate). The lack of a clear policy regarding dementia patients, not only among institutions but within institutions, further diminishes the quality of care for these patients (Teno, et al., 2016).

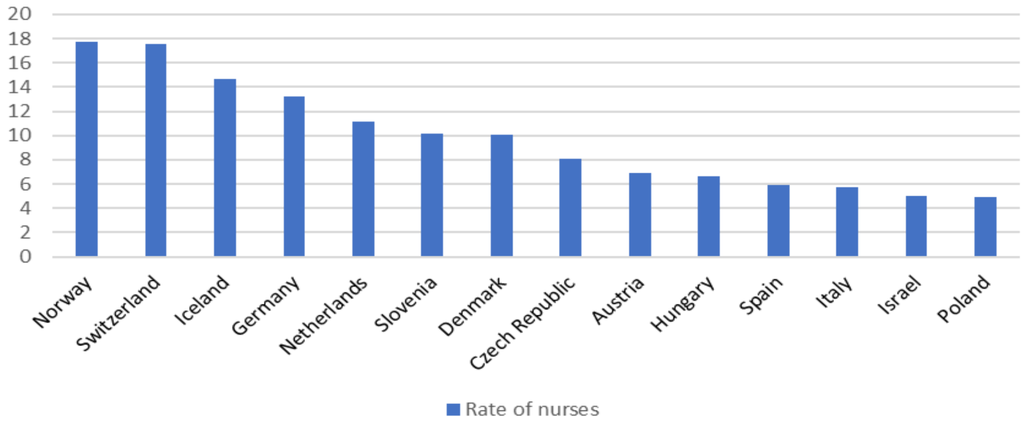
1.3. The main characteristics of nurses in Israel, compared to OECD countries.

In Israel, the nursing profession encompasses practical nurses, certified nurses, and those who have completed a recognized advanced professional training course in a clinical field. Prospective nurses, whether educated in Israel or abroad, must pass the government licensing exam, obtain recognition from the Ministry of Health, and be listed in the nursing registry.

As of the end of 2018, there were 68,543 licensed nurses in Israel, with 79.3% of them under the age of 67, amounting to 54,361 nurses. This equates to approximately 6.06 nurses per 1000 people. However, it is essential to acknowledge that not all licensed nurses actively practice. Between 2015 and 2017, an average of 43,000 nurses were employed in Israel, with approximately 83% of licensed nurses actively working. The majority of nurses work in hospitals, with the remaining employed in community settings (Central Bureau of Statistics, 2024; Eurostat, 2024).

When compared with other OECD countries based on the number of employed nurses per 1000 people, Israel falls below the average. In 2018, Israel ranked 21st out of 25 OECD countries with approximately 5 employed nurses per 1000 people. This places Israel below the OECD average of 8.7, highlighting a disparity in the employment rate of nurses in the country compared to other OECD members (Eurostat, 2024; Central Bureau of Statistics, 2024).

Figure 1: Rate of practicing nurses per 1000 people, 2018 in OECD countries.



The proportion of nursing workers in Israel over the age of 55 increased from 23% in 2000 to 39% in 2020. Compared to countries such as Poland and Greece, where the proportion of nurses per 1000 population is even lower than in Israel, the proportion of caregivers over the age of 55 is significantly higher. So in the coming years, the challenge of filling the ranks will be even greater (Israel in Figures Selected Data From the Statistical Abstract of Israel, 2022).

1.4. Caregivers: competence, pressures and professional burnout.

Caring for physically dependent patients in daily activities is a complex and difficult task for the caregiver, both mentally and physically. The variety and increase in challenges involved with this type of treatment significantly affect the caregiver's life and over the years the negative aspects of this work are considerable. Many studies report continuous and unavoidable harm to the physical and mental health of the caregiver. Caring for an elderly dementia patient presents additional challenges to caregivers and thus contributes to the development of prolonged stress, burnout, and depression. The progression of dementia, involving cognitive deterioration and loss of function in the patient adds to the emotional and physical burden for the caregiver. Over time, a dementia patient needs more and more hours of care over many years. As a result, caregivers for elderly people with dementia need to dedicate more physical work hours than caregivers for patients with other chronic illnesses (Malak, et al., 2016). This point is not at all surprising, since caregivers for the elderly in general and especially for dementia patients, show higher levels of emotional stress and burnout, suffer from depression, and exhibit poorer health than other caregivers. This can be explained by a variety of characteristics that the elderly develop while dealing with dementia, such as cognitive decline and changes in the personality of a dementia patient, aggressive and socially unacceptable behavior, a constant decline in physical abilities, and loss of basic functions, such as dressing, eating and maintaining personal hygiene. Dementia patient care increases the caregiver's long-term emotional burden and causes the development of chronic physical and mental health problems that require medication and hospitalization (Karg, et al., 2018). One notable example of this is the oral/comfort feeding of the elderly with cognitive decline. Elderly feeding requires time to establish a positive personal connection between caregiver and patient and is based on the ability of the caregivers to complete their responsibilities. This interaction also becomes more intense and demanding, raising possible tension in communication and tantrums on the part of the patients towards the team. Thus, over time, the caregiver team develops feelings of incapability, frustration, sadness, and depression, which are clear consequences of the inability to carry the burden of increasing care-based tasks (Austbo Holteng, et al, 2017).

When raising the issue of care for elderly patients with dementia, it is important to note that in addition to constant damage to personal health, caregivers are socially disadvantaged, resulting in a significant decline in their quality of life. This damage has a devastating effect on the lives of the caregivers and their families, especially when it comes to informal caregivers, such as spouses and family members of an elderly dementia patient. Informal caregivers for dementia patients report giving up the maintenance of their private life, social isolation, sadness, and anger. Additionally, the unemployment rate among dementia patients' caregivers is significantly higher than in other patients’ caregivers (Karg, et al, 2018). This situation is similar among formal caregivers as well, whose daily work is filled with death, dying and grief. Over time, caregivers develop relationships with the elderly people they care for, and when they die the caregivers feel separation pain, and even grief. Under these circumstances, the high rate of caregivers for elderly dementia patients leaving their profession is not at all surprising (Marcella & Kelley, 2015).

The need for a caregiver is understandable and obvious, especially when it comes to caring for the helpless, such as elderly people with dementia; at the same time, in a hospital setting, nurses limit care for dementia patients to basic daily activities: showering, feeding, and diaper changing. This "bodywork" on which caregivers choose to focus allows them to work quickly and to take care of many patients at once, that is, to treat them without emotional involvement and empathy. The distance that caregivers create in this way comes from their desire to protect themselves from emotional burnout (Martin, et al., 2016). Marcella & Kelley (2015) agree with this point. In their opinion, nurses refrain from expressing an emotional attitude toward the patient for fear that this behavior may be interpreted by co-workers as unprofessional. On the other hand, lack of emotional involvement in feeding an elderly person with the added pressure of time and impatience, not only undermines the goals of "end-of-life comfort care", but directly damages both parties. Thus, successful feeding as well as positive feelings on the part of the caregiver depends on effective communication between the caregiver and the patient in calm conditions (Austbo Holteng, et al, 2017). At the same time, the ability of the caregiving team to focus on the "technical components of the treatment" allows for completing multiple routine tasks in a short amount of time and the freedom to focus on other tasks that are equally as important when it comes to care (Marcella & Kelley, 2015, p. 12). So, to get a patient emotionally involved in treatment and to provide a comfortable emotional basis, the caregivers themselves must be taken care of. A caregiver who is in mourning and experiences mental emptiness and sadness reaches exhaustion and is unable to carry out compassionate treatment (Marcella & Kelley, 2015).

1.5. Caring for the medical and emotional needs of patients suffering from dementia.

Care for elderly patients with dementia is a unique and multidisciplinary practice. Alongside the mapping of medical issues directly related to dementia, such as memory, dysphagia, confusion, and more, reference is also needed to other chronic illnesses in the elderly. That is to say, quality care for elderly people with dementia also includes treatment that is not directly related to dementia. Furthermore, the quality of dementia patient care should be based on the comprehensive and multidisciplinary perspective of the caretakers, with the health-medical aspect being one of a variety of areas addressed. In addition to the medical field, care for the elderly should also include social, mental, and spiritual considerations (Malak, et al., 2016). Other scholars also support this claim though, in their opinion, the emphasis should be on the patient's mental needs. Properly addressing mental needs allows for the provision of individualized and thoughtful care to elderly patients. Also, when the psychological needs of the elderly are met, it is easier to go beyond providing basic daily care (such as feeding, personal hygiene, etc.) and medical care (such as providing medication and treatments, follow-up, and physical exams). These findings are not at all surprising. Medical and nursing care involve physical contact between the caregiver and the patient and therefore require the creation of a mutual trust base in this area. It is worth noting that creating a trust base between the elderly patient with dementia and the caregiver is particularly difficult due to the cognitive deterioration that characterizes dementia (Hansen, et al., 2017). It should also be noted that elderly people with dementia do not resemble other patients suffering from cognitive decline due to their illness. Dementia patients exhibit similar symptoms and signs to cancer patients with a wide spectrum of needs. However, this group of patients does not receive proper supportive care, like that received by cancer patients in the terminal stages of their illness. For example, about 90% of all patients referred to palliative care were cancer patients while dementia patients referred to palliative care were a negligible minority. One logical explanation for this is that dementia is not currently fully identified as a terminal illness. Another explanation for the fact that dementia patients are not referred to a supportive medical service is that supportive treatment for dementia is much more prolonged than that for cancer patients, and care for dementia patients should also be provided in the patients’ natural environment, without transferring them to a formal and unfamiliar treatment setting (Martinsson, et al, 2018; Hansen, et al., 2017).

Moving patients from a familiar setting to a strange environment with new and unfamiliar caregivers, often causes anxiety, agitation and aggression. This means that hospitalization for dementia patients, especially in the advanced stages of their illness, is a particularly traumatic event. Thus, preventing hospitalization and providing appropriate care in a patient's natural environment is a key goal of dementia patient care (Pohontsch, et al, 2017). One of the key examples of supportive care for elderly people with dementia is coping with an eating disorder (dysphagia) that develops during dementia. Even though this eating disorder is a major symptom of dementia, there is widespread agreement among family members and professional caregivers that dementia patients suffer from hunger and thirst when approaching death due to their lack of ability to consume food and drink. Additionally, many family members and caregivers agree that introducing a feeding tube may solve the problems of hunger, thirst and insufficient consumption of food (Arcand, 2015). As a result, improving nutrition status by introducing a feeding tube is the most common prejudice among family members of dementia patients. The responsibility for spreading this feeding tube myth has to do with caregivers who have not been trained to work with elderly patients with dementia. Additionally, there is a widespread belief that a feeding tube prevents aspiration and prolongs life. These myths and others influence family members' and guardians' decisions to insert a feeding tube. This is in contrast to the fact that eating disorders associated with dementia result from loss of function at end-of-life stages (Hwang, et al., 2014). Findings from researchers around the world contradict the idea that the introduction of a feeding tube improves an elderly patient's dietary status. Studies show that a feeding tube not only does not improves the nutritional status of an elderly patient with dementia, but also does not inhibit gastric content aspiration to the lungs, nor does it increase the life span of dementia patients. In addition to this, the insertion of a feeding tube involves the possibility of complications, such as gastrointestinal pressure ulcers, intestinal perforation, infection, and bleeding. Any of these complications can cause the death of an elderly person. Thus, in a group of dementia patients, in contrast to other groups of patients, the damage resulting from inserting a tube outweighs the benefits of using a tube (Arcand, 2015). As opposed to this, comfort feeding prevents the patients from feeling hungry or thirsty and involves only minor complications. Comfort feeding or manual feeding involves providing small meals at set feeding times for elderly patients with dementia, providing small amounts of fluids, and even oral treatments. The benefits of manual feeding among dementia patients outweigh the benefits of all other types of feeding. Comfort feeding allows for a more sensitive and humane treatment. Personal feeding increases the time of social interaction for the patients as well as the human contact that is so important in their treatment and is thus a key component of end-of-life care. Though all of this is true, based on cultural and moral standards, family members of the patient and some professional caregivers advocate for the use of a feeding tube. This is because the human resource shortage in caregivers may result in less quality feeding or no feeding at all. Despite the families' fears, skilled, professional and knowledgeable caregivers should explain to families that personal feeding is well-suited to the needs of the patient and can also be performed by family members, especially when there is a limited number of caregivers. It should be mentioned that the possibility of aspiration also exists in comfort feeding, although the risk of this is significantly reduced with manual feeding in comparison to tube feeding (Arcand, 2015). Furthermore, as the disease progresses the role of feeding introduces a more enjoyable, joyful and comforting experience. The significance of feeding is particularly intensified because in the terminal stages of the disease feeding no longer improves nutritional status nor raises medical prognosis of survival, but enables humane and supportive care (Austbo Holteng, et al., 2017). Contrary to well-established findings, according to data from US researchers, in reality, 23.2% of patients with dementia who are hospitalized at the end of their illness receive food through a feeding tube, and about 63.4% receive mechanical feeding through an orogastric tube (into the stomach through the nose - non-invasive feeding). This is a result of the fact that inpatient institutions have too many patients and too few caregivers. The number of elderly dementia patients receiving manual feeding is very small and therefore negligible (Teno, et al., 2016).

During the final stage of the disease, when there is a significant deterioration in the dementia patient, various conditions (such as infections, hip fractures, strokes, etc.) require that caregivers make immediate decisions to provide treatment in situations that are referred to at times as medical emergencies and cause invasive intrusive and non-intrusive artificial ventilation. Additionally, preventing death at a terminal stage of dementia becomes an impossible task for caregivers. For example, pneumonia caused by the aspiration of the stomach contents to the lungs, despite the intensive inpatient treatment, causes risk of patient death within six months to a year of the event (Arcand, 2015). As a result, the mechanical ventilation rate for patients over 65 in the last decade has risen by 30%. During the same period, the number of dementia patients intubated for treatment saw more than a fourfold increase. Despite a sharp increase in invasive medical interventions among dementia patients, the benefit of these interventions, including mechanical ventilation, remains unclear because it has not been sufficiently studied (Lagu, et al., 2016).

According to guidelines for the treatment of dying patients in Switzerland, oral health assessment must be done in 90% of all dying patients, regardless of their diagnosis, and pain must be assessed and well documented in all patients. Additionally, analgesics and antidepressants should be given to 98% of all patients for at least six months before death. Despite these general requirements, none of the patient groups has achieved the stated goals. Dementia patients achieving these goals are at the lowest level in the country compared to cancer patients and patients suffering from other diseases (Martinsson, et al, 2018). Like other patients, dementia patients also need quality supportive care, but due to a lack of treatment planning, they do not receive basic support during the end of their lives, similar to that which other patients receive. For example, dementia patients need medical assistance for daily activities in their natural environment and need unique social services more often than cancer patients. Also, compared to other patients, dementia patients develop more bedsores towards the end of their lives; and receive less intravenous fluids, more feeding tubes, and less oral feeding. As a result of this sad reality, dementia patients receive much worse treatment than cancer patients and patients with other chronic illnesses at the end of their lives. Differences in end-of-life treatment in dementia versus cancer patients or other chronic patients may be due to cultural differences in the treatment of the elderly and dying patients in the society in which the therapeutic encounter occurs. This insufficient treatment and lack of dignity-based care now characterize the healthcare system worldwide (Martinsson, et al., 2018). Additionally, researchers from England claim that cognitive decline is a major barrier to receiving treatment of any kind. In their opinion, urgent medical conditions that require immediate treatment for dementia patients are identified only after many complications have emerged. In light of this, hospitalizations of elderly patients with dementia become longer, and more expensive and result in poor outcomes with low rehabilitation potential. For example, a fractured hip condition in the elderly requires immediate surgery that allows an elderly person full rehabilitation in the future and a longer life of better quality (Gill, et al., 2017).

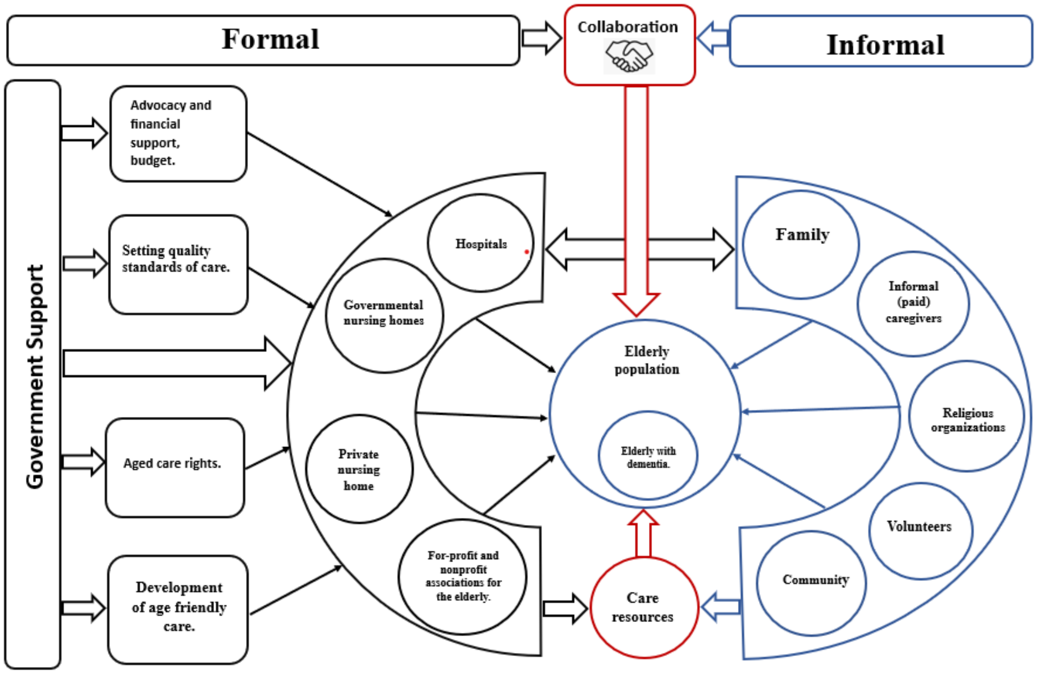
Healthcare systems in many countries have adopted this practice as a measure of quality in medicine. However, in the case of dementia patients, the elderly are usually unable to alert their caregivers of the fracture due to cognitive decline and their caregivers are unable to diagnose it immediately. Thus, the period between fracture and medical intervention is significantly lengthened and impairs therapeutic and rehabilitative capacity (Gill, et al, 2017). Researchers from Canada also agree with this point. Dementia patients at advanced stages of the disease have a high medical emergency referral rate compared to other elderly people without dementia (Martin, et al., 2016). This is noticeable in institutions that provide urgent medical services to patients with dementia and see life extension in patients as the sole purpose of treatment, along with an almost total neglect of quality of life (Arcand, 2015). Researchers from the United States agree and add to this notion, addressing the example of mechanical ventilation. Although mechanical ventilation of an adult/elderly person is a life-saving procedure, with its benefits outweighing its harm to the quality of life in older patients, this is not the case for dementia patients. Artificial ventilation, which is usually invasive, also causes life extension for groups of patients with dementia, although this extends suffering and eliminates the quality of life of dementia patients at the end of their lives. The intrusion of invasive ventilation and its other shortcomings significantly outweigh its benefits for a patient with dementia (Teno, et al., 2016). On the other hand, lack of intervention in respiratory distress may be interpreted as unethical, as it is an immediate cause of death. Thus, both choices may be equally detrimental for the dementia patient (Lagu, et al., 2016). Another example of harming the quality of life in dementia patients is the poor treatment of pain among dementia patients. For example, in England, between 25% and 42% of patients in public hospitals are treated for dementia, with about 57% suffering from pain accompanied by movement and 16% suffering from pain while resting. In an environment of unfamiliar caregivers, bright lights that are often turned on, noise, and lack of pain management, the patients' suffering and aggression towards caregivers are more severe. As a result, more than 75% of hospitalized dementia patients receive psychiatric medication with severe side effects instead of receiving an effective analgesic. This behavior of caregivers towards dementia patients increases the risk of further cognitive decline and death (Lichtner, et al., 2016). Other researchers present similar examples. Researchers from Germany, for instance, argue that the inpatient mortality rate for elderly people with dementia is twice as high as the mortality rate for elderly people without dementia. The severity of this statistic is heightened as the findings suggest that in some cases hospitalizations of dementia patients are not only unnecessary but also preventable (Pohontsch, et al., 2017; Fleming, et al., 2017).

Rehabilitation treatments also display a difference in the quality of care when comparing elderly people and elderly people with dementia. According to Gill and colleagues (2017), in elderly patients with dementia, a functional outcome after hip fracture treatment is 63% worse than for elderly people without dementia. Furthermore, during hospitalization in the field of emergency medicine, the survival length of elderly patients with dementia is reduced by half compared to elderly people without dementia of the same age. Thus, the treatment provided to this group of patients is not only delayed and shows a lack of good results, but is defined as poor and even harmful. As a result, surgeons are reluctant to care for elderly patients with dementia, knowing in advance that the chance of success is not only low, but also not financially worthwhile due to long hospitalization periods (Gill, et al., 2017).

Many researchers agree that the modern caregiver is very far from providing high-quality care to elderly people with dementia. Despite being one of the leading causes of death in the elderly, dementia is still not recognized as a terminal illness. Reference to this disease is based on a medical and economic perspective only. This prevents the development of the spiritual and psychological aspects and reinforces a patronizing attitude towards these patients alongside insufficient and harmful treatment (St John & Koffman, 2017). It is noticeable that elderly people who suffer from dementia have different material needs than elderly people without dementia. Problems with speech and understanding, lack of ability to express needs or ask for help, functional decline – all disguise their real needs, which as a result, are not identified by caregivers and therefore are not addressed (Gill, et al., 2017). Thus, Fleming and her colleagues (2017) argue that about 95% of dementia patients prefer a comfort-oriented end-of-life over any medical intervention aimed at improving survival. That is to say, to improve the quality of care for elderly patients with dementia, elderly people suffering from dementia should be at the center of care. Care for these patients and their families should be culturally tailored, taking into account their personal needs and preferences for the end of their lives (Fleming, et al., 2017). Beyond multiple care-oriented tasks, modern caregivers have forgotten basic patient needs, such as the need for human contact, identity and privacy, reciprocity and communication, comfort and mental well-being and social belonging (St John & Koffman, 2017, p. 355). Additionally, dementia patient care must be based on open communication between a multi-professional staff and the patient, which will enable the patient and his or her family to understand the nature of the disease and formulate the strategies for optimal treatment later on. Optimal treatment of dementia patients reduces the discomfort associated with their condition, promotes the patient's physical and mental well-being, reduces the side effects associated with medical interventions, and builds upon the values of the elderly, formulated throughout their life. The optimal treatment for these patients can easily move on a therapeutic continuum between quality of life in the shadow of illness and quality of death. This is a moral practice, full of universal honor for the patient on the side of his or her caregivers. Quality treatment also reduces stress and anxiety among family members who, in the later stages of the illness, make decisions in the medical arena. It is a treatment that draws its strength from mercy, compassion, and emotion, which are generated as a result of maximum human interaction and minimum technology (Arcand, 2015). Researchers from England also support this claim, in their opinion, the universal basis of care, which is also true for dementia patients, is the treatment that begins with human contact, possible only with human interaction full of appreciation and respect. The importance of this value is especially intensified when treating the helpless, such as dementia patients (St John & Koffman, 2017). Furthermore, for different patients the idea of a comfortable death in a quiet family environment is an integral part of the best care plan, but none of the existing frameworks for dementia patients offer this option. Many institutions, especially hospitals, provide elderly patients with dementia with bad, disrespectful, inhumane care and a complete absence of spiritual support. These conditions are worse when a dementia patient ends his or her life in hospital. That is to say, not only are the spiritual needs of patients with dementia ignored, but their medical needs are also neglected, even near death (St John & Koffman, 2017). According to many researchers, it is time to listen to elderly people with dementia to map out and understand the quality of care from the perspective of these patients and their family members. It is time to understand the concept of - "Not adapting the patient to the caregiver team, but making sure the caregivers adapt to the patient". It is also important to understand that there is no single solution. The most successful solutions are unique to each country and tailored to society according to social and cultural values and norms (Hansen, et al., 2017, p. 3). Thus, to build quality care specifically for dementia patients, Geriatric Counselor Joyce Simard (USA) has developed the "Namaste Care" program, "Namaste" meaning respect with spirituality. The program was later adapted and tested in several countries, including the United States and England.

The program is designed for people who are no longer able to enjoy social activities as they did in the past, those who suffer from acute mental deterioration, those who spend many hours sleeping, those with limited verbal abilities, and those who are restricted in terms of normal daily activities. The program involves activities that stimulate many emotional facets (such as touch, music, color, flavor, massage, aromatherapy, etc.). The "Namaste" program is based on the study of family members and includes medical and nursing care. Providing quality care as part of the program was made possible by improving communication between the caregiver team and patients, as well as raising awareness of dementia among the caregiver team. Although the program is in its early stages, its results are of great interest (St John & Koffman, 2017). In the Netherlands, for example, in order to achieve quality treatment for dementia patients, "Green Care Farms", were established; these are long-term care institutions for elderly patients with dementia. According to researchers from the Netherlands, sooner or later, patients with dementia end up in institutions. It is very important to anticipate this, as a successful solution for finding proper care for this population needs planning and preparation. The idea that guides the institution is meeting the unique needs of each patient. The "Green Farm" is a new type of institution for the elderly. The therapeutic emphasis is on building a small family framework that provides intimacy for elderly patients. The "Green Farm" is located in nature, away from big cities, and combines therapeutic and agricultural activities. There is no single plan and no universal intervention that can be created to treat dementia patients. The only solution is to use creativity while responding to the needs of a dementia patient and his or her family and conducting research that promotes the topic for building an evidence-based practice (de Boer, et al., 2017).

Figure 2: The support system for the elderly in Israel.



In general, the support system for the elderly in Israel is divided into two parts, formal and informal. The two parts influence one another, while effective collaboration between them contributes to the well-being of the elderly person, in particular the elderly person with dementia.

At the head of formal support, there is the government, the Ministry of Health. Its area of responsibility is allocation of the budget according to needs, legal protection of the elderly, setting care standards and supervising their achievement, maintaining the upholding of the elderly patients’ rights, transfer of information regarding rights and services for the elderly as a target population, development of user-friendly medical and nursing care services for the elderly people and their families, and so on. In addition, the Ministry of Health sets the policy and supervises the activity of institutions such as hospitals, private and government old age homes, health maintenance organizations (HMOs), and other institutions that provide different services for the elderly population, such as different associations for the senior citizen, whether they were established for profit or other purposes. It is important to mention that when institutions for the elderly are well-managed by a government that determines clear care goals, defines objectives, and ascertains the achievement of desired outcomes, the elderly person receives trustworthy, elderly-focused care, at the proper time. The guidelines for the provision of medical services obligate the formal caregivers, such as physicians, nurses, and other workers in the healthcare system.

When speaking about the rights of the elderly, special emphasis is placed on the right to be given care with respect and to receive appropriate care that includes the caregiver’s professionalism and evidence-based actions. The caregiver must ensure safe, complete, and correct care while taking into consideration the elderly patient’s identity and desires. In other words, elderly people have the right to obtain information and make medical and care decisions regarding themselves, after they have received from their caregivers the relevant information in the correct form. In addition, all elderly people have the right to receive care in privacy, including total protection of the medical information and any other sensitive information regarding their lives and medical situation found in the caregiver’s hands.

The most significant actor for most of the elderly is the family. The family not only is the main provider of the elderly person’s needs but also enables initial care in severe illness, post-surgery or hospitalization recuperation, and continuous care throughout the period of old age. Thus, the family members who are the most prominent in taking responsibility for the elderly person’s care are the elderly person’s spouse and children. However, sometimes the family members, for their own reasons, cannot take upon themselves the elderly person’s care and invite a paid caregiver into their home. If the economic situation does not allow the hiring of paid caregivers, then the family is helped by volunteers and religious organizations in providing the elderly person’s daily care. Also, there are clubs for the elderly that provide leisure time activities. Besides, the community in which the elderly person lives creates activities to instill meaning in the elderly person’s life. It should be noted that there are organizations of volunteers that also are a part of the formal support system and help with all sorts of tasks in the institutions of the healthcare system.

The two parts of the support (formal and informal) ensure the fulfillment of care resources for the elderly person. However, a gap is created between what the elderly people require (according to their health situation and their and their families’ economic situation) and the care resources that they can obtain, which enable the elderly and their families access to formal and informal support.

Dementia, as discussed in this chapter, is a chronic, progressive disease characterized by a decline in intellectual abilities, with memory loss being the most prominent symptom. This global health concern is projected to see a dramatic rise, with patient numbers expected to soar from 30.8 million in 2010 to over 106 million by 2050. This translates to a staggering 1 in 85 adults worldwide potentially developing dementia. By 2050, it's estimated to be the seventh leading cause of death, claiming 1.6 million lives annually.

The rise in dementia cases will significantly strain healthcare systems, particularly in Western societies. This is partly due to an anticipated increase in elderly institutions, where many dementia patients may spend their final years. However, the burden extends beyond institutions, as elderly individuals with dementia living alone often struggle to receive proper care due to undiagnosed or misdiagnosed conditions. Early identification of symptoms, proper treatment plans, and supportive living environments are crucial for improving patient outcomes and reducing unnecessary hospitalizations and deaths.

A recent study in Israel highlights the need for improved dementia care. While caregivers appreciate the country's advanced medical care, they criticize the care provided for the elderly, especially dementia patients, as impersonal and lacking in compassion. They advocate for a more holistic approach that prioritizes respect, a supportive environment, and staff trained specifically in dementia care. Opinions differ on the use of invasive procedures in later stages, with some prioritizing life-saving measures and others favoring palliative care based on individual wishes. Overall, the focus should be on creating a more humane and patient-centered healthcare system that prioritizes the well-being of elderly individuals with dementia.

2. Quality of life as a sociological concept.

Quality of life is the level of happiness that the individuals feel according to their success in fulfilling their needs in life. While the concept of quality of life is subjective, it has a broad shared basis. From time immemorial mankind has attempted to explain the feeling of happiness and to compare it among different people. In addition, people want to know how different changes (such as technological, political and social changes) over time influence the population's quality of life. How has the life of the current generation changed in comparison to the life of their grandparents?

This interest in changes and differences in levels of quality of life between different groups in society, and intergenerational changes in social groups, led to the performance of different public opinion surveys. William Sevel, in his works from 1940, maintained that in the year 1918 there were initial assessments of the livelihood conditions of families. For this evaluation, use is made of factors such as socioeconomic status of the family and level of life. Based on data from sociological research studies from 1917, William Sevel built a second scale according to which he evaluated the standard of living of families on an Oklahoma farm. In addition, in 1939 McKain compared the city-dwelling population and the town-dwelling population in his works. In his opinion, the influence of factors such as electricity, radio, plumbing in the house, and the use of cars caused essential changes in everyday life between the city and the town. Even then, however, use was not made of the term 'quality of life' (Ferriss, 2004). These reviews led to the construction of different measures that help evaluate and compare different factors that influence the individual's perception of his or her life (Mollenkopf, et al., 2007). Already in 1941 Cottam and Mangus coined a new concept 'standard of living', which addressed life satisfaction and included three components: level of life, social participation and social adjustment (Ferriss, 2004).

Already in the 1960s and early 1970s in the works of William F. Ogburn and Howard W. Odom, different social indicators had begun to appear in sociological research studies. In parallel, many sociological scientists began to work on theory and an empirical basis to develop tools for the evaluation of the well-being and quality of life of a society. In 1975 Land and Spilerman added data for a theoretical basis for the understanding of well-being in society (Huges, 2006).

In 1985, Schussler and Fisher reviewed works on the quality of life and found that ‘Sociological Abstracts’ was the first which uses the concept of ‘quality of life’ as one of the categories in sociological research, in 1979. However, when they refer to a ‘good life’, they are referring to happiness (Ferriss, 2004).

As the universal basis for the evaluation of the individual’s quality of life, many factors have changed throughout the development of research on the topic. The common ones accepted by most of the researchers are the subjective assessment of the individual, belief in one’s personal control in life, economic resources, connections and networks of social support, national policy of wellbeing, environmental factors, and so on. The micro approach to the quality of life focuses on the importance of the individual’s psychological and personal factors, such as mental and physical well-being. In contrast, the macro approach attempts to see a more complete picture and examines the individual’s mental well-being in different social, economic and cultural contexts. In other words, an individual is a part of the family and society to which he or she belongs, and therefore his or her perception of quality of life is related to social support networks, cultural customs, and national and environmental conditions (Mollenkopf, et al., 2007).

For example, changes that occurred up to the 1960s that influenced the individual’s everyday life led to changes on both the personal and social level. The struggle between different societies for their achievement of social rights, economic globalization, and so on caused a change in the system of values and norms on the personal and social levels. The change in the perception of justice and equality set complicated challenges for cultures and societies and shattered social conventions that had been accepted until then. Thus, it is necessary to see in the concept of ‘quality of life’ the general well-being of the individual and society. Quality of life is multifaceted, and therefore it is a mistake to see it as the level of life that is based primarily on income. According to a sociological approach, quality of life is not only riches but also the environment, mental and physical health, education, leisure and free time, and social belonging (Abdel-Hadi, 2012). In his previous review of the literature, Ferriss (2004) addressed factors alongside the importance of the individual’s economic income and ability and saw meaning in the integration of factors such as family status, religion, religious customs, and residence in an urban or rural region (Ferriss, 2004).

Research studies in the field of the individual’s quality of life tended to focus on the personal perception and economic contexts of livelihood. The sociological approach to the quality of life through research studies linked the individual’s quality of life to different social factors but proved the importance of these factors in the understanding of the individual’s quality of life. The most prominent social factors are housing, health, education and social support (Abdel-Hadi, 2012; Mollenkopf, et al., 2007). Another advantage of a sociological perspective is the inculcation of the understanding of cohesive factors that make life possible in one society, despite a subjective perception of quality of life that changes from individual to individual (Huges, 2006).

Subjectivity in the definition of mental well-being and quality of life builds a comfortable arena for the performance of psychological research studies on the topic of the individual’s quality of life. However, sociological research studies on the topic enable diversification in the factors that influence the perception of a good life and are not related directly to the individual; they also prevent a paternalistic approach to psychology (Mollenkopf, et al., 2007). Another advantage of a sociological approach is that works that take into account a variety of social factors, such as cultural differences, social movements, and globalization, enable the drawing of conclusions regarding quality of life in a wide variety of societies and aspire to a more universal understanding of the topic (Abdel-Hadi, 2012). Although the perception of the individual’s quality of life is subjective, the needs that the individual wants to fulfill on the way to a good life and happiness are determined by different social factors in the society in which the individual lives (Mollenkopf, et al., 2007).

A review of the literature, concluded by Ferriss, that included works performed from 1940, found that only a few works include the concept of ‘quality of life’ according to the definition. While many works mention a variety of components of quality of life, such as satisfaction, happiness, and wellbeing, in parallel, there are works that address phenomena such as inequality following gender belonging, racial inequality, and inequality of single-parent mothers, with decisive influence on the quality of life but do not mention the concept itself. During the historical development of sociological research studies that indicate a relationship between satisfaction with life and different social phenomena, such as crime and social supervision, social structure education, and social classes, the concept of ‘quality of life' was defined as a constellation of economic opportunities, social health services, an environment that encourages behavior to achieve good health, leisure and cultural activity, and minimal crime rates. In addition, 'quality of life' from a sociological perspective should be mapped alongside 'social quality', where this concept addresses social economic security, social inclusion, level of social cohesion, and social empowerment and often constitutes a part of 'quality of life' (Ferriss, 2004).

2.1. Current research on quality of life.

Quality of life is a subjective concept. It depends on the individual's perception of his or her life. Different people in different periods of their lives tend to evaluate the quality of their lives according to changing values and norms. People during their lives tend to attribute different weights to different values according to their current importance in their lives. Although this concept is defined as subjective, there is agreement among the researchers that, alongside the subjectivity of the concept, there is a variety of shared components between people in their perception regarding the concept of quality of life (Mottus, et al., 2012).

Despite the subjectivity of quality of life, the performance of research studies on the topic enables the characterization of the existing resources that help the individual cope with life events more effectively. In addition, they re-evaluate the contribution of these resources according to the changing conditions in the personal, social, and environmental dimensions. The understanding of the quality of life, in its components, for individuals and their families enables the creation of better conditions for their lives. When good conditions for the promotion of the quality of life are created, there is a decline in the level of mental stress and a rise in mental and physical well-being, even if individuals suffer from chronic mental illness (Bertelli, et al.., 2011). In addition, research studies indicate that when individuals define their quality of life as good, their satisfaction with their decisions and with the steps they took during life increases. They feel accepted and calm, and thus mental health at later ages is reinforced (Forte, et al., 2015).

Research conducted in India shows that an in-depth understanding of the variety of factors that influence the quality of life not only will help improve the living conditions from childhood to old age in the general population but also will help develop instruments and policy for coping with discomfort and burnout among different caregivers. Finding an answer to the question of ‘what influences the quality of life of caregivers?’ will reduce the rates of depression and other mental illnesses among caregivers of dementia patients, will reduce burnout and departures from the workplace, will increase satisfaction derived from work as a caregiver for dementia patients, and will contribute to the medical care service to dementia patients at an advanced stage of their illness (Srivastava, et al., 2016).

The relationship between health and quality of life has always received the attention of many researchers around the world. Moreover, the World Health Organization defines the individual’s health as mental, physical, and social wellbeing, regardless of the presence or absence of chronic illnesses. There is decisive agreement among researchers around the world that different factors related to health (such as access to health services, the quality of the health services, etc.) (Fassio, et al., 2013; Mollenkopf, et al., 2007) influence the individual’s quality of life and the reverse is true. If the individual’s health is better, the individual will tend to appraise his or her quality of life as high. In addition, people who suffer from chronic illness and who live in a comfortable environment define their quality of life as high relative to people who suffer from the same chronic diseases but in a less comfortable environment, in their opinion. However, conclusions drawn from the research studies that address the relationship between health and quality of life do not always enable the performance of a comparison with different populations, even in the same region or state, because of the considerable variance of the subgroups in these populations (Fassio, et al., 2013).

Regarding the quality of care of the patient who is suffering from a chronic illness, the improvement of the patient’s quality of life is the primary consideration in the management of care. Furthermore, research on the quality of life of different patients helps in finding factors for the improvement of these patients’ mental wellbeing, increases the effective care given to them, prevents burnout at work, and increases the quality of the care given to the patients. In other words, today, the quality of care of patients, especially patients who are helpless, such as dementia patients, directly and indirectly, is influenced by the quality of life of the caregivers who provide everyday care (Olsen, et al., 2016). Livingston et al. (2012) extend this argument, maintaining that when the patient has a terminal disease or is an old person at the end of his or her life, the understanding of the meaning of the quality of care at the end of life enables proper planning of the care, with the utmost consideration of the true needs of the elderly and the terminally ill patient (Livingston, et al., 2012).

However, some researchers do not agree fully with this argument. They assert that there are social groups in the population (such as care recipients of mental health services) who do not evaluate the quality of their lives and their mental wellbeing. In other words, at no stage of the characterization of the concepts and the understanding of the quality of life among patients who suffer from mental illnesses does the quality of life represent the true opinion of the patients themselves (Connell, et al., 2014).

Another group that constitutes a research challenge when an attempt is made to understand the perception of the quality of life is the group of dementia patients. In this case, too, the evaluation of the perception of the quality of life and mental wellbeing of dementia patients is performed by caregivers, medical staff, and family members, and not by the patients themselves, even if the dementia from which the patient suffers is not at a high degree of severity (the state at which it is not possible to hold a conversation). Furthermore, the evaluation of the quality of life and mental wellbeing of these patients is performed using a system of symbols, norms, and desires of the patients and family members. Sometimes, to provide explanations of the dementia patient’s quality of life, use is made of interpretation of events from memories that the family members and/or caregivers bring up when for the most part they are not partners in the world of values and norms of the patients themselves and do not even know them. To characterize the quality of life for social groups that are supported by relatives and live with the family, it is necessary to examine the quality of life of the family as perceived by the nuclear family that lives with the individual and assumes upon itself care and concern, as in the case of dementia patients (Ducharme & Geldmacher, 2011).

Quality of life includes the following three main aspects: individual, interpersonal, and contextual. The individual aspect addresses the individual’s physical and mental health, expectations and beliefs, personality and traits. The interpersonal aspect addresses social interactions, while the contextual aspect addresses the social environment. These three aspects exist in two dimensions, objective and subjective, and are influenced by many other factors. The individual's perception and evaluation of these aspects determine the level of one's mental wellbeing over the course of one's life and shape one's perception regarding the quality of life (Fassio, et al., 2013).

Connell et al. (2014) in their work in the field of mental health maintain that there is no one universal definition of quality of life. For every social group in the population, there is a quality of life unique to it. In other words, today the quality of life is examined to address a variety of issues: social mobility, self-care, regular everyday activities, level of pain, discomfort, depression and anxieties, physical functioning, physical handicaps, social functioning, mental health, and vitality. The following question should therefore be asked: in every evaluation of the quality of life is it necessary to ask the same questions and to examine the same areas? According to researchers, evaluation of the quality-of-life accepted today is not suited to many social groups in the population, such as, for instance, groups of patients with mental illness at a very severe level (such as bipolar disorder and psychosis) in a poor physical health situation. For improvement in the understanding of the quality of life among patients who suffer from chronic mental illness, another six parameters should be taken into consideration: mental wellbeing versus ill-being, control and autonomy versus choice, self-perception, belonging, and hope versus lack of hope (Connell, et al., 2014). In addition, to evaluate the quality of life among groups of patients who suffer from dementia, researchers based their work on five factors: family reciprocal relations, treatments or everyday activities, mental wellbeing, cognitive wellbeing, and the need for medical assistance or dependence on another person for the performance of different everyday activities (Ducharme & Geldmacher, 2011).

Many years ago, close reciprocal relations were already apparent between the individual's health and his or her quality of life. The World Health Organization (WHO) defined quality of life as the individual's perception of his or her status in life in a cultural light, according to his or her system of personal values, goals, expectations, and personal standards (Mollenkopf, et al., 2007; WHOQOL Group, 1998). It appears that reciprocal relations balanced between the individual, intrapersonal, and contextual aspects enrich one another while increasing the quality of life as perceived by the individual while maintaining the uniqueness of every aspect. The works found that the individual's attitude toward the environment in which he or she lives influences not only the mental wellbeing as self-evaluated but also his or her perception of the quality of life (Fassio, et al., 2013).

Several factors in the research studies that influence the individual's quality of life over the course of his or her life were characterized. There is agreement among researchers that the individual's economic-social characteristics are the most influential, with significant influence on a variety of other factors. It is important to note that the individual's economic and social characteristics can contribute to the individual's subjective positive perception regarding the quality of life. To the same extent, these characteristics may cause the individual's perception of the quality of life to be negative, depending on the individual's personal abilities and traits (Fassio, et al., 2013). When researchers examined the perception of the quality of life of a family who cares for a patient with cognitive limitation, it was found that the economic aspect in the quality of life is evaluated highly and is considered one of the most important factors after the importance of health. It is important to note that the researchers themselves assume that the reason for the significant weight of the economic aspect in the perception of the quality of life was the unbalanced economic situation in the country in the period in which the research study was performed (Bertelli, et al., 2011).

This finding is not surprising at all. Individuals' priorities are determined by their values, which change throughout their life, according to their goals in life, their age, their desires, and their affiliation with different social groups (such as, for example, the family). If certain values are important to the individual, then he or she will act to realize them. When the fulfillment of important values occurs, the individual is filled with positive emotions, such as hope, mental wellbeing, and happiness. However, when different factors have a detrimental influence and the values are not fully realized or are not realized at all, the individual will tend to feel negative feelings, such as lack of hope, sadness, mental distress, and so on. In periods when the individual does not succeed in fulfilling in his or her life a personal system of values over time, the individual may develop mental illnesses (such as depression) or chronic illnesses may be exacerbated (Bertelli, et al., 2011; Connell, et al., 2014; Godwin, et al., 2015).

Fassio et al. (2013), in an attempt to characterize factors that contribute to the improvement in the quality of the individuals' life, maintain that family status, when referring to marriage, contributes significantly to an increase in the quality of life. The health of the married couple was evaluated in the research as better. In other words, married couples report a higher quality of life in comparison to single people, divorced people, and widows. Additional factors of influence are gender and age. They play an important role in the contribution to the quality of life. Thus, for example, women because of the multiplicity of social relations display high levels of quality of life in both the psychological and environmental dimensions. Moreover, age has the opposite impact on quality of life. In other words, as age increases, the quality of life decreases significantly. However, when the influence of the individual's chronic illness and health situation is taken into account, the importance of age as a negative influence on the quality of life declines significantly. In addition, research studies around the world on different social groups have proved that physical functioning and physical illness, which until now have been at the center of the concept of quality of life, can no longer explain fully the quality of life without additional elements. Possible components are poor mental health, the perception of mental well-being in the shadow of illness, as perceived by patients themselves and not by their caregivers (Connell, et al., 2014).

2.2. Quality of life of the elderly.

Simone de Beauvoir in her work "Old Age" saw the period of old age in a person's life as half-life and half-death. She believed that most people who reach this age, which is defined as old age, accept this with great sadness or rebellion and find it difficult to bear. She asserted that death is not the opposite of life. Old age is the opposite pole of life, a degeneration, an erasure of memories and social status. Old age is the individual's unending struggle with the indifference that the old people encounter, with the pain they bear, the illnesses that accompany them, with the loss of wisdom (de Beauvoir, 1996).

Gogwin et al. (2015) in their research study on a group of the elderly in Canada convey criticism about the reference of the rest of society towards the elderly as a unit.

Advanced age itself does not harm the individual's perception of quality of life. Aging is a long but natural process that causes the individual's values and norms not only to obtain different weight but also to change completely. People following significant life events change the priorities of their values, and consequently their perception of mental wellbeing and quality of life change. For instance, one of the most significant values among older people for the evaluation of the quality of their life as high in their lives is the lack of dependence on others and independence in everyday activity but for young people this value is not found to be a high priority (Godwin, et al., 2015). Apparently, functional ability at a young age is perceived as obvious. Another important value in old age is the desire for a tranquil death. This value is at the top of the list of priorities, in light of the mental acceptance of the end of life. In contrast, among young people, this value, too, is not found to be significant, since death is not perceived as important at this stage. In addition, values are not universal. They are dependent on the culture in which the social interaction exists. Therefore, it is possible that in other cultures the desires of young people and old people will be different from those that arose in a research study of a population in Taiwan (Manasatchakun, et al., 2016). Furthermore, a research study conducted in Italy found that quality of life in old age takes into account the quality of death. Like the quality of life, the quality of death is a subjective concept, depending not only on the individual's culture and system of values but also on the individual's chronic sickness, its severity, and its influence on cognitive and physical functioning in everyday life (Forte, et al., 2015).

Like modern changes in the rest of the countries of the world, the modern change in traditional residence of old parents in China, from living together to living in an arrangement different from what was accepted, has a detrimental influence on the elderly people's satisfaction with their lives. Those who did not succeed in continuing to live with their children, as accepted for generations, and who were forced to find a different arrangement for residence reported a low quality of life and more than others suffered from depression in old age. In parallel, some elderly people who lived with their children according to tradition were not satisfied with the situation. Some suffered from a type of dissatisfaction with their lives, but they did not tend to be depressed (Guan, et al., 2015).

Han et al. (2015) maintains that among all the factors that have an influence, the psychological resources and abilities of the individual are especially prominent, including self-efficacy, self-achievement, and ego-integrity. These are factors perceived as essential to the life of every individual, without differences of age. They are vital to the achievement and preservation of the quality of life on a high level in old age as well. Another factor that influences the perception of quality of life is the presence of leisure activities in life. Leisure activities constitute strong prognostic indicators of good aging. In general, the lack of leisure time activities in life, as well as their low level, predicts the appearance of depression in adult life, especially in old age. Depression detrimentally influences wellbeing and constitutes a very significant risk factor for health at all ages, especially in old age (Han, et al., 2015).

Similarly, according to Erikson's theory (Erikson & Joan, 1997), a person throughout his life, from childhood to death, is engaged in the resolution of the conflicts between internal biological needs and social requirements. Erikson divided the person's life into eight stages where each stage is characterized by a task or a conflict that demands a solution. The person's development depends on providing solutions to conflicts in the stages of life. The successful or unsuccessful coping with conflicts instills different tools and with them a good ability or the lack of such ability to deal with the task in the last stage of life – 'old age'. Erikson believed that from the age of fifty the retrospective look at life influences the person's negative or positive perception of old age. At this stage, the elderly person summarizes achievements and failures in life. When people evaluate that they have more achievements in life than failures, then they will feel 'ego integrity'. In other words, they accept their life, their feelings, and the events that occurred, they feel satisfied with their old age, and they accept death. However, when people feel despair and fear of death, they display a sense of bitterness, and regret for what was done in life, a feeling that they have missed out. Such people will tend to depend on others and will display great difficulty accepting the end of life. If elderly people succeed in coping with the conflict between despair and ego integrity, then they will achieve wisdom and will succeed in retaining independence in making decisions. Wisdom enables elderly people to profoundly understand life and to accept it without negative emotions, such as frustration and a feeling they have missed opportunities. The achievement of ego integrity in old age not only brings with it positive emotions such as acceptance of life events and death but also causes better health in old age. However, when people do not develop correctly in this stage of life, they give the responsibility for making decisions, even day-to-day ones, to another person. In parallel, they are emotionally closed, their level of physical activity declines, and they cease social and family relationships. The same is true in the health arena. When the elderly have acquired wisdom in old age, they display a higher level of self-management than elderly people who find themselves despairing and frustrated. In other words, although old people suffer in old age from a decline in their physical and cognitive abilities, the elderly who achieved wisdom show a better level of health than those who feel disappointment and despair regarding the events in their lives. Furthermore, the elderly who independently decide to move to an institution have a longer life than other old people. An old person who has successfully acquired tools in the early stages of life succeeds more easily in adjusting to the changing social role and accepts more easily the decline in physical ability. Moreover, an old person who has reached ego integrity succeeds in identifying more opportunities in life and in using them for his or her benefit and the benefit of his or her environment. Furthermore, he or she is socially active, contributes to his or her environment, and more easily copes with crises in life. In contrast, elderly people who did not successfully solve the task in the stage of old age experience a decline in all areas of life. Thus, alongside the cognitive and physical deterioration, they surrender autonomy in making decisions and tend to develop greater and worse chronic illness than do elderly people who have resolved the conflict more successfully in the stage of old age (Erikson & Joan, 1997).

According to de Beauvoir (1996), during old age, elderly people suffer from a lack of renewal and lack of the ability to invent innovations; or the environment halts the old person’s ability to invent. In her opinion, the solution is to allow the aging person to be helped by relatives in matters of social activity, politics, and creative activity. She believes that for a successful old age, it is necessary to maintain desires, so as not to decline into regression. De Beauvoir (1996) writes that life has value in old age when there is a relationship with others and when there is love and friendship (de Beauvoir, 1996).

Last, according to Castells (2010), modern society enables a good life also at advanced ages. In other words, old age in itself no longer constitutes "social death", but is another milestone, a new beginning. Old age may even constitute a turning point for a life that is freer than the previous one (Castells, 2010, p. 476).

Social death causes an extreme withdrawal from social roles, including that of a spouse (as a result of the death of a spouse), a parent (as a result of raising children), and a friend (as a result of the weakening of social ties because of, for example, a health condition). Social death is a social mirror of the elderly person's choice or social necessity, the reality – to withdraw from all social activities, such as relationships with family or friends, participation in religious activities, or hobbies. Admittedly, it is important to remember that this is a reversible death Ducharme & Geldmacher, 2011

In research studies that have addressed the quality of life among patients who suffer from mental illnesses, the agreement is that depression constitutes a significant risk factor for harm to the quality of life, as it is perceived by the patients themselves and their caregivers. However, feelings of calm and tranquility, or feelings of elation help the individual maintain mental wellbeing and constitute significant protective factors in the achievement of the highest quality of life possible, not only when there are mental illnesses but also in full health (Connell, et al., 2014).

Additional factors that contribute to the explanation of the perception of the quality of life are consistent reciprocal relations, a sense of social belonging, and the feeling that others love you and care for you. These are the main components in the achievement of quality of life, both in sickness and in health. The presence of chronic mental or physical illness is harmful to the perception of the quality of life far less than the lack of feeling of happiness for long-term periods (Connell, et al., 2014). On the one hand, social belonging, feelings of love and concern for close people who love you and on the other hand, concern and caring for people you love even in sickness are components found at the basis of the perception of quality of life of all those who participate in the process (Ducharme & Geldmacher, 2011). Therefore, it is not surprising that the perception of the quality of life of the family as a social unit is higher than the perception of the quality of life of the individuals that compose it. However, researchers in their work on the perception of the quality of life of the family as a unit hold that along with the concern and caring in the family that suffers from an illness or physical disability there is a heavy economic burden, needs that are not satisfied by society and expectations from the environment that are not fulfilled. Often the family that cares for a sick relative with cognitive disabilities encounters a harmful social attitude, is pushed to the social margins, and is found in social isolation (Bertelli, et al., 2011).

Another factor raised in the work of Guan et al. (2015) which increases the perception of quality of life is the expression of opinions. In other words, when older people can express their opinions and act according to their preferences, at least in the field of the choice of residence, their satisfaction with their lives rises and the mental discomfort entailed by the expected change in their life declines. The choice of residence has decisive influence on the topic of belonging to and absorption in the community (Guan, et al., 2015).

Simone de Beauvoir (1996) recommends planning for old age. In her opinion, this planning is not only the saving of money for old age and the choice of residence upon retirement but also the acquisition of different hobbies and living a life of involvement that will provide an opportunity for the continuation of a real life (de Beauvoir, 1996).

Some researchers maintain that successful integration in the community and the presence of an extensive social support network in the individual’s life not only contributes to the individual’s mental wellbeing and health but also improves the quality of life. When environmental factors that influence the quality of life are examined, such as residence and integration in the community, it is necessary to address the density of the population. For instance, a highly crowded residence causes the individual’s quality of life to decrease. However, when residence in rural regions is compared to urban regions, the density of the residence assumes a different meaning. In other words, a high density of residence in the city causes a decline in the quality of life. In contrast, the same density in the village likely has an opposite impact. In other words, the density of residents in a village may contribute to the quality of life. While there are not enough research studies that can explain this (Fassio, et al., 2013), according to Guan et al. (2015), at an older age more than in youth, residence in a familiar environment is important. In addition, the elderly prefer to remain with their adult children in a familiar environment where they have lived until now. The reality, in contrast to cultural values, dictates to the elderly people's children that they leave home and the familiar residential environment, to search for a better life, and thus cause the elderly person to shift his or her residence to another place that is unfamiliar or to remain alone. The lack of fit between the elderly's ability and desire to choose their future residence leads to a gap that is too great between reality and preferences. This gap causes a sense of harm to the self-efficacy to make decisions, and the elderly person's satisfaction with his or her life declines (Guan, et al., 2015).

In reality, things appear less complicated. Modern cities are for the elderly (even for those who are healthy) a hostile and frightening environment that creates an atmosphere of insecurity and helplessness, which does not effectively deal with changes that occur in the environment and community of the city. It seems that every urban change that takes place is characterized by the creation of conditions unsuitable for the lives of the elderly, which become more and more aggravated if the elderly are ill. Thus Rosochacka-Gmitrzak (2016) concludes that cities should be friendly for senior citizens. She claims that there must be easy access to medical services because this is the population that consumes the service at the highest rate compared to other social groups. In addition, urban infrastructures should not only suit the cultural and social interests of the elderly who live in the city but also should offer a safe environment, which enables a good socio-cultural life in the city. Furthermore, a city adapted to an aging population offers various activities for quality leisure time and shopping (Rosochacka-Gmitrzak, 2016).

When the residential neighborhood in late adulthood and old age is discussed, it is necessary to address the existence of an appropriate neighborhood environment. The lack of a comfortable environment or the prevention of reciprocal relations with the environment harms the elderly person's physical and mental health and reduces his assessment of the level of his quality of life. In other words, the presence of neighbors constitutes a factor that protects against cardiovascular disease. In addition, existing in an appropriate and desired environment ensures the elderly person suffers only low levels of pain related to daily activities, shortens periods of recuperation from severe illnesses, and in general, improves the elderly person's general health. There is a significant relationship between quality of life and emotional-mental disorders. In other words, social isolation increases the risk of the appearance of depression and anxiety. In contrast, being with neighbors, in a good, supportive and appropriate environment, as the elderly see it, constitutes a protective factor and prevents the appearance of deterioration in the elderly person's emotional and mental state. However, a similar impact was not found in the younger population. The convenience of the neighborhood and the environment in which the residence is found do not contribute to the improvement of the young individuals' mental state (Mottus, et al., 2012).

According to Bertelle et al. (2011), the environment has considerable importance but far more important are relations within the family and the nature of reciprocal relations, regardless of the presence of chronic, physical or mental illness of family members. It is possible to explain this through the relativeness of cultural values and norms. For instance, in Italy, families and communication with the family are the supreme cultural value that influences all dimensions of the individual's life, regardless of age differences (Bertelli, et al, 2011).

Without a doubt, the family situation of the elderly is quite complicated: on the one hand, the elderly do not want to be a burden on their relatives. On the other hand, the quality of their lives depends on the status they have within their families, the frequency and quality of the relationships, the persistence of the relationships, and the level of acceptance by their families (Mottus, et al., 2012).

In addition, a strong relationship was found between self-efficacy and the results of life, reciprocal relations, work, health, and healthy and active aging. In addition, the combination of self-efficacy, a sense of self-fulfillment, along with high self-esteem at an elderly age, ensures better mental health and mental wellbeing at a level that is necessary in the process of healthy aging (Han, et al., 2015). Research studies performed in the population of China give rise to similar data. When an elderly person can express active agreement with a change of residence as a part of his preferences, when he is not forced to submit to a situation created in reality, the elderly person will tend to be more satisfied with his life. Thus, the fulfilling of personal preferences at an old age not only contributes to the positive perception of quality of life but also helps bridge the cultural requirements in society (Guan, et al., 2015).

Similarly, Rosochacka-Gmitrzak (2016) asserts that modern society is found at the start of the process of aging and has increased life expectancy through enhanced social services and improvements in quality of life. Thus, it is not possible in this stage to provide unequivocal and satisfying explanations of the phenomenon. The development of institutions and services suited to the provision of services for the elderly are found in the process of structuring and growth and have not reached the fulfillment of potential. One thing is clear already today: the most effective social approach for coping well with the aging of the population is making cities friendly for the elderly. According to this researcher, the friendly city may be based on policies and services aimed at active aging and on a society that encourages a physical and social environment planned for the complete acceptance of the elderly person in it. Active and healthy aging is impossible without minimal conditions that encourage it, such as a safe environment for comfortable living, good health, and full and productive participation in the social life of the city. An elderly-friendly city provides a full and thorough response to the needs of the elderly while addressing nine main areas: the comfort of public surfaces and buildings, urban transportation, adapted housing, participation in social life, respect and integration, employment, communication and information, environmental support, and advanced medical services. Urban changes that enable progress should include the desire of the elderly to enhance their participation in society and make it more meaningful for them and for society as long as their health permits it (Rosochacka-Gmitrzak, 2016).

Some researchers maintain that not only is the quality of life a subjective concept but also the perception of the quality of life changes according to changes that occur in the individual’s life, from youth to old age. As in youth, in old age, the quality of life of the elderly is influenced by the individual life style throughout the entire life span, from childhood to adulthood, regardless of the loss of physical abilities, which frequently in old age entail the presence of a chronic illness. Healthy, positive and active aging raises the requirement for the understanding of special needs in old age to achieve a quality of life at a high level in old age. Healthy aging is a long process. In the continuation of this process, an individual is asked to better the quality of his life through the promotion and maintenance of his physical, mental and social wellbeing (Han, et al., 2015).

Quality of life in old age is based on health more than it is in youth and requires the constant fulfillment of the aging individual’s physical, spiritual and mental needs for the achievement of wellbeing. In other words, mental and physical wellbeing require far greater effort in advanced adulthood than in the individual’s youth. When healthy aging is discussed, in comparison to childhood and youth, it is necessary to address the issue of personal autonomy and independence, the ability to perform different everyday activities without dependence on another person (Han, et al., 2015). Despite prejudices in society regarding old people, who are perceived as a group of people lacking ability and with a poor functional level, many elderly people are found in a good health situation. They live alone without any outside help and their level of social activities is high. They contribute to the community in which they live and they are still involved in the social life of their family and friends. In other words, the individual’s age is not the only factor influencing the quality of life (Godwin, et al., 2015; Illouz, 2007).

Alongside a variety of social factors, the elderly person should be aware of the responsibility he bears for the quality of old age (as a chronological period of his life), while taking care of his development throughout life and continuing learning late in life. In addition, the elderly should develop an optimistic attitude and remain open to contact with other people. However, the social system is also supposed to carry out the tasks assigned to it, such as intervention in a social crisis and education for old age. In Mottus's, et al, (2012) opinion, this can be done by building intergenerational relationships, ensuring equal access to social life institutions, including health services and the job market, and conducting awareness campaigns that help improve social awareness of old age among society as a whole over its generations (Mottus, et al., 2012).

When the relation between the quality of life and the functional ability of the individual is discussed, it is important to take into consideration not only the individual’s coping with everyday physical activities but also cognitive abilities in the performance of different tasks in everyday life. Many research works have noted the relationship between the quality of life and the functional ability of the individual in his youth, adulthood, and old age. In other words, there is a significant relationship between quality of life and everyday physical functioning. As the physical functioning is evaluated by the individual as better, the individual perception of quality of life is increased. In addition, today little is known about the relationship between the cognitive level of functioning and the perception of quality of life. There are also research works that found a relationship between the individual’s quality of life in old age and his cognitive abilities in his youth. However, few works attempt to prove and explain the relationship during aging (Forte, et al, 2015). Moreover, when the issue of quality of life and mental wellbeing is discussed, physical disabilities and physical illness are taken into consideration, and not only are the individual’s cognitive abilities neglected but also mental illnesses, if these exist (such as schizophrenia, personal disorders and anxieties). In other words, there is sparse evidence in the literature addressing the quality of life that examines the quality of life as perceived by patients with mental illnesses, such as extreme anxiety or difficult personal disorders (Connell, et al., 2014).

The process of aging for the most part is influenced by other factors, such as education, family status and health condition. It is customary to think that as the individual gets older, his health situation gets worse. However, it is necessary to accept the fact that not every old person is a patient who needs help in his everyday life and is not involved in the life of society. Furthermore, an old person who suffers from managed chronic illnesses does not necessarily need help in the performance of everyday activities (Godwin, et al., 2015). However, in the literature, there exists between the researchers agreement that in advanced adulthood the individual’s satisfaction with his life depends on good physical functioning in everyday activity. However, there are research studies that maintain that a good physical condition in old age reflects a higher level in the individual’s health situation and the reverse is also true. When there is a decline in the individual’s everyday functioning, a decline in his health condition can be expected. In other words, some research works maintain that excellent physical functioning contributes greatly to the individual’s quality of life, mental wellbeing, and satisfaction with life (Forte, et al, 2015).

Good health in old age also includes good mental health, or in other words, lack of depression, high self-efficacy, good coping with loneliness, and avoidance of social isolation. When all these needs are fulfilled satisfactorily, even in the presence of certain chronic illnesses, the quality of life is evaluated by an adult at a high level. Isolation and social loneliness are factors that influence the individual’s life negatively. Their influence is more decisive in old age (Han, et al., 2015). Mottus et al. also see the residential area (neighborhood) to be an important factor in the coping of the old person with the feeling of loneliness. In addition, their research found a strong relationship between the presence of a comfortable environment and the quality of life of the individual. An old person spends far more time at home and near to it than do young people. Therefore, it is likely that the elderly person is far more dependent on the community and neighborhood sources. Thus, easy access to health services and different social services, the presence of neighbors with a common denominator, and a low rate of crime in the residential area contribute to the elderly person’s satisfaction with his environment and increase the level of his quality of life. When the old person avoids having reciprocal relations with his environment and neighbors, there is harm to the quality of life, and the level of physical and cognitive health declines. In addition, regular reciprocal relations with the neighborhood improve the elderly person’s control and contribute to his autonomy, enjoyment in life, and self-fulfillment in aging (Mottus, et al, 2012). Furthermore, a move of residence in old age to an unfamiliar place and in a surprising manner may be not only an undesired event but also a traumatic one and may induce anxiety. Moreover, when a move entails the acceptance of treatments following the deterioration in the old person’s health situation (such as a move to an institution) the harm to the elderly person’s mental wellbeing may be irreversible (Shaw, et al, 2016).

A decline in social activities and several social relations, loss of close people, reduction of reciprocal relations, change of place of residence following a decline in physical ability or health deterioration – all these and others may harm the old person’s mental wellbeing (Han, et al., 2015). Also, the promotion and maintenance of mental wellbeing while aging are possible through the performance of moderate physical activity and a healthy lifestyle. Walking in old age, as a recommended physical activity, constitutes a protective factor against cognitive and functional deterioration (Forte, et al., 2015).

The most comfortable environment that encourages the full and long-term functioning of the elderly by preserving their ability will not be created by itself. In the opinion of Rosochacka-Gmitrzak (2016), the transformation of a city as it is known into a city that is friendly for the elderly is possible through a smart urban policy that will cause the development of: "…generational intelligence that is such an attitude that recognizes the areas of differences and similarities appearing in generations, creates the conditions for negotiations of generational ambivalence, navigates and facilitates intergenerational relations in the context of the city." (Rosochacka-Gmitrzak, 2016, p. 99)

An environment that is good and appropriate for the elderly not only makes old age a more pleasant period but also makes social attitudes towards the elderly and their care more positive, with the creation of a better future for the young generations. Society’s willingness to accept the elderly is a complex and lengthy process that requires the investment of thought and consistency (Shaw, et al., 2016).

Conversely, the research study of Han et al. (2015) indicates that mental wellbeing and mortality among aging people are influenced significantly by their beliefs and perception of their health as ‘good’ or ‘poor’, regardless of the objective severity of the illness in medical terms. In other words, when old people perceive their health as better, they report a higher level of mental wellbeing. In addition, lower rates of mortality were observed in this group of the elderly. In Italy the situation is similar. Spiritual and cultural beliefs have a very significant influence on the perception of the family's quality of life; they reinforce emotional support in the family and help maintain reciprocal relations with the community. The importance of beliefs in life and the strength of their influence on the perception of quality of life rise with age. In other words, the process of aging is accompanied by the strengthening of beliefs (Bertelli, et al., 2011).

The rise in the life span in the population, which characterizes most Western countries, requires decision makers to understand how to maintain health at a good level along with quality of life at a high level in later adulthood and old age (Forte, et al., 2015; Mottus, et al., 2012). The issue of the general aging of the population of the world has become a main topic discussed in many forums – public, health and social. As in many countries in the world, in Taiwan the health system is coping with issues caused by the aging of the population. Old people reach ages where they experience loss of functions and the appearance of chronic disease. A decline in physical abilities and personal illness necessitates the individual to allocate resources differently from how he was accustomed to in his youth. Moreover, the burden of the care of the sick or healthy elderly person relies on the economic capacity of the family in which the person ages. Frequently, children of elderly parents are expected to take the burden of the elderly person’s care upon themselves. For example, in Taiwan, which is influenced by the principles of the Buddhist religion, it is customary for children to play an active role in the care of their aging parents since the parents had cared for the child when the child was small. However, modernization has detrimentally influenced the ability of the nuclear family to provide a security net for the aging person, while searching for a better economic life. Children of elderly parents move their residences to new places and leave their aging parents behind in their homes. Today it is clear that, in parallel to the rise in the rate of the elderly in society, the family as a social unit can no longer bear the burden of care for adults alone, without help from society and the state (Manasatchakun, et al., 2016). A similar situation is occurring in China. Here too, as in many countries of Asia, the son bears the responsibility for the care of his parents at a late age. However, following the rapid aging of the population and the policy of family planning and birthrate reduction in China, there has been a considerable decrease in the ability of the nuclear family to care for the elderly. Therefore, the percentage of the elderly who live outside of their families has steadily increased in recent years. Today, adults in China, in contrast to tradition and culture, live alone, with their spouse, or in old age homes (Guan, et al., 2015).

The process of aging, in good health or illness, requires high economic investment, not only on the personal-family level but also on the level of society and the state. To properly evaluate the needs of the elderly and to enable effective intervention, it is necessary to research the perception of people regarding the quality of life from childhood to old age. Today, there is insufficient knowledge regarding the perception of the quality of life among the elderly. In addition, there is confusion regarding the different concepts in the literature. Some not only were not defined at all but were defined differently among the research studies. For instance, healthy old age is defined as devoid of illnesses or as active old age or functioning without help, and so on (Godwin, et al., 2015; Manasatchakun, et al, 2016). Han et al. (2015) broaden this argument. In their opinion, it is necessary to characterize all the factors throughout the individual’s life that influence old age to be interpreted in the individual’s eyes as good and active or as negative. In addition, the implementation of the order in the multiplicity of concepts related to the quality of life, especially in old age, will facilitate a better understanding of the term.

Godwin et al. (2015) maintain that the group of adults in society is one of the most heterogeneous groups in society. The division that exists today into healthy or ill is very arbitrary and does not reflect the true situation. Their research study among adults conducted in Canada indicates that there is a group of elderly above the age of 80 who function independently in everyday activities, are cognitively alert, are involved in the life of society, community, and family, are very highly educated, with high motivation to integrate socially. The needs and desires of these elderly people are different from the requirements of the elderly with different backgrounds, aside from age. In addition, the results of the research study performed among elderly people in Korea indicate that taking medications for managed chronic illnesses is not at all related, in the opinion of the elderly, to quality of life and therefore does not detrimentally influence the perception of quality life, although unmanaged severe or chronic illness detrimentally influences the quality of life, as perceived by the elderly (Han, et al., 2015). Reference to the group of the elderly by society based on age harms the quality of their lives. A precise characterization of criteria that influence the perception of the quality of life at old age alongside the understanding of heterogeneity in this age group not only will help the makers of decisions improve the health services provided in the community for this age group but also will improve the perception of the quality of life among the elderly. Thus, they will contribute to the improvement of the elderly person's general health (Forte, et al, 2015).

The characterization of the needs of the elderly population first and then the construction of a constellation of social services and health services for them will contribute to their full integration into society and will improve their mental wellbeing. The understanding of the needs of the elderly person in society will allow maximum adjustment of the services necessary for the elderly person, his family, and his community, for the preservation of his independence and physical and cognitive functioning in his natural environment, in which he lives. Shaw et al. (2016) maintain that the implementation of a humanistic approach on the social level towards the elderly person in society will help unite all the relevant issues and build holistic references that will see the elderly person not only from the perspective of health services but also from the perspective of the elderly person. Furthermore, healthy aging is not only the characterization of the elderly person's needs; this is a process of decisions that the individual makes in many areas of his life for the promotion and preservation of mental and spiritual wellbeing as well as mental and physical health. All these constitute a significant part of the influence on the elderly population's evaluation and perception of the quality of their lives (Han, et al., 2015).

Simone de Beauvoir maintained that society has fated the elderly to misery and even to poverty, to inappropriate and uncomfortable residence, and loneliness. She sees this type of attitude towards the elderly to be the complete responsibility of society. She blames the society of the 1970s for the creation of the situation of handicap and misery in old age. De Beauvoir holds that society is filled with painful obstacles and has a terrible attitude in moral terms. In reality, the elderly are powerless and empty-handed, and when their power leaves them they are 'thrown away' by society, tossed to the margins as trash. The elderly person is weak and all that remains of him from all he had in life are his two eyes - to cry. In her opinion, this must not happen. De Beauvoir maintained that improvement in the situation of the elderly cannot be accomplished only by raising pensions, providing fair housing, and organizing leisure activities; rather it is necessary to have a more extreme and profound change – a change of life (de Beauvoir, 1996).

2.3. Quality of life of the elderly with dementia.

The aging of the population constitutes one of the most important topics in the modern era. It brings with it many social and economic challenges. According to the frequency of the elderly in the population, the frequency of chronic illness related to old age is steadily increasing. One of the chronic illnesses most identified with aging is dementia. It is frightening, because of its cognitive harm, the suffering it causes families, and the burdensome private and public expenditure. Dementia requires extensive resources, and there is considerable public discussion on the topic (Philips, 2016; Skoldunger, et al., 2016).

About 47 million people around the world today suffer from dementia. In parallel with the aging of the population around the world, this number is continuing to grow, and by the year 2050, the number will reach 131 million patients. In the year 2015, the cost of dementia in the world reached 818 billion US dollars. It is expected that in the year 2030, it will grow to a trillion US dollars (Philips, 2016). The estimate of the cost of dementia constitutes a decisive factor in the planning of health sources around the world. As a chronic illness with a duration of four to eight years and high economic demands, it constitutes a serious challenge, not only for the patient himself and his family but also for the health systems in the world (Ku, et al.., 2016).

In Spain, the percentage of dementia patients in the population over the age of 65 ranges from 5.2% to 16.3%, and above the age of 85 this percentage exceeds 30%, or in other words, around 500,000 elderly people suffer from dementia. This data, along with the etiology of the illness, makes dementia one of the main concerns in the planning of health services in the future for this population (Farre, et al., 2015). In England the situation is similar. About 50% of people above the age of 65 suffer from confusion, cognitive decline, or dementia (Tanajewski, et al., 2015).

The high percentage of the elderly and the tremendous demand for medical services and daily treatments expose a lack of real data regarding the private and public economic expenditures on the treatment of dementia patients. According to researchers from China, a correct and true estimate of the expense of the treatment of dementia patients is necessary to determine future policies in the world, especially in China. The reason is that a higher percentage of elderly people than of working people, along with a continuing rise in the life span and the policy of reducing the birthrate (the single child policy is now canceled), may lead to a situation of lack of caregivers for dementia patients not only in the public sector but also in the family (Wittenberg & Hu, 2016). In Thailand, too, the percentage of Alzheimer's patients (a common type of dementia) among the elderly above the age of 65 ranged in the past from 1.7% to 4.3% and the last estimate reached 4.8%. However, the real figures are far higher. For instance, the estimated cost of treatment for a dementia patient was set at 86,637 Thailand dollars. The research findings indicate that the cost is significantly higher, even when the progress of the disease is taken into account. In other words, the cost of care for a dementia patient ranged from 122,363 to 178,141 Thailand dollars, when as the disease advances the cost is higher. One of the main recommendations in Thailand is the performance of cost appraisals on an annual basis, which does not happen. Therefore, the gap between the real cost and the estimated cost of care for dementia patients according to the severity of the disease is created (Ku, et al., 2016).

The data are also not reassuring in North America. Dementia is one of the most common chronic situations especially among the population above the age of 65. Today more than 5.2 million people above the age of 65 suffer from Alzheimer's. Up to the year 2050, every eighth elderly person will suffer from dementia and the total number of patients with the disease will reach about 16 million people. The same trend is observed in Canada: from a population of about 36 million residents about 750,000 suffer from Alzheimer's. More than 40,000 Canadians above the age of 65 develop the disease every year. It is expected that by the year 2030, the number of Alzheimer's patients will double to 1.4 million patients (Hazzan, et al., 2016).

According to data presented by Germany in 2005, there were 19,400 dementia patients in the population over the age of 65. According to the forecast based on the incidence of about 250,000 new cases of dementia, in the year 2020, the number of dementia patients will increase by 80%-91% in comparison to the data for 2005 (Thyrian & Hoffmann, 2012).

Japan presents similar data. In 2010, about 2.5 million elderly people were diagnosed as suffering from Alzheimer's. In 2012 in the population above the age of 65, the percentage of Alzheimer's patients is 16.8%. The slow course of the disease causes the loss of physical and cognitive functioning of the patient with an estimated cost of about 145 billion dollars a year when the private cost is not included at all in these data (Goren, et al., 2016).

Treatment needs attributed to dementia entail a social cost and utilization of health resources at a high level. For instance, in Europe, the estimated cost of health services for dementia patients is about 160 billion Euros. In Spain, the direct cost of health services is more than 9,000 Euros for every dementia patient a year, while the indirect cost for dementia reaches about 19,000 Euros per patient a year when the dementia is mild to moderate. However, when dementia is at an advanced stage, the indirect expense ranges from 32,000 to 52,000 Euros per patient per year (Farre, et al., 2015). Alongside the high consumption of health services, dementia poses another challenge that must be addressed– the high cost of medications and their cost to the health system. Research conducted in Switzerland compared the amount of medications in use and their cost among the elderly and found that elderly dementia patients take more medications and their cost is higher in comparison to the elderly who are ill with other chronic diseases. The cost of medications in the general population reaches 4,000 Swiss Francs a person a year, while the cost of medications in the population of elderly dementia patients is higher by 60% and even by 80% when this is an elderly dementia patient who is in an institution and not in his home. For instance, between the years 1994-1996 elderly dementia patients above the age of eighty used 2,806 Swiss Francs for medications, while the elderly without dementia used about 2,539 Swiss Francs, and as the disease worsens, the cost of medicinal care rises. In addition, elderly dementia patients found in institutions use more medications than those at home, regardless of the severity of the dementia. The differences in the high consumption of medications that lead to a high cost can be explained by the high use of medications such as laxatives, psychotropic drugs and opioids (Skoldunger, et al., 2016).

In the beginning stages of the disease, dementia patients for the most part are cared for within family frameworks. In other words, 90.5% of caregivers for dementia patients are the spouses and children of the patients themselves (Philips, 2016). In the initial stage of the disease, the care entails relatively minor help in everyday activities and less need for advanced health services, such as hospitalizations and complex medical interventions. However, as the disease advances, dementia patients need continuous help and continuous professional supervision, which for the most part are not possible at home but only in institutions. Formal treatment in an institution entails especially high direct expenses and still does not cover the true cost of the care of patients in the advanced stages of the disease. Today, about 87% of the general cost of the care for the dementia patient is invested by the family and only 13% comes from public funds (Farre, et al., 2015).

In addition, in Canada, too, most of the patients diagnosed with Alzheimer are cared for in their homes instead of in an institution for end-of-life care or other settings adjusted for the care of dementia patients. About 80% of dementia patients who are cared for in their homes are cared for by their spouse or their children (Hazzan et al., 2016).

Furthermore, expenditure on care is greatly influenced by the speed of the loss of functional and cognitive abilities and the appearance of additional diseases. For instance, expenditure on the care for a dementia patient with a significant behavior disorder reaches 1,956 Euros a month on average (or 23,120 Euros a year). When the dementia is more advanced, the cost of the care doubles. The expense for the care of the dementia patient may be even higher but there is no more accurate estimate since most of the expense comes from the budget of the patient and his family members who provide the care. In addition, the caregiver's time is not taken into account, since for the most part the help provided to the patient in everyday activity is provided by the spouse and the close family (Farre, et al., 2015). Philips (2016) broadens the argument, stating that most of the facts in the estimate of the costs and the private and social expenses of the care of dementia patients are not accurate and are often significantly lower than the reality. Moreover, the care of the dementia patient is an exhausting role that requires considerable time and is filled with frustrating tasks with physical and mental costs that the caregiver himself pays. In addition, the estimate of the social costs is restricted only to the costs of the use of medical services, physician visits and hospitalizations. There is no doubt that immediate economic expenses (such as the use of medical services) are important, but they do not cover the true care of the dementia patient. It is likely that additional social expenses and private expenses for the care of the dementia patient will have serious implications in the long term (Philips, 2016). According to the findings of the research from Thailand, while the cognitive state and functional limitations of the dementia patient directly influence the cost of the care of the patient, the weight of this influence differs. In other words, the cognitive state influences the non-formal cost. The decline in the dementia patient's functional ability adds to the cost of the care in social terms more than the actual medical expenditure (Ku, et al., 2016).

The general trend in Europe for family members of elderly dementia patients is to provide the maximal care in the dementia patients' home, or in other words, in the family. This trend derives from cultural behavior patterns, according to which children are supposed to provide care for sick parents, and the lack of capacity in health systems in particular countries, which today are noted for the lack of structured constellations adjusted to dementia patients at the mild and moderate stages of the disease (Farre, et al., 2015). Even when there is a social constellation that can offer social and medical services to the population of dementia patients, the care provided in these frameworks is of low quality and high cost. Thus, the benefit of the care that the dementia patient receives in the institution is significantly lower than the price required for the service and care (Tanajewski, et al., 2015). In addition, in Spain about three-quarters of the expense of the care of dementia patients is placed on the shoulders of the patients themselves and their family members, when only one-quarter of the expense comes from the budget of the health system and this quarter is invested in institutions for ongoing care in the end of life. However, in the countries of Northern Europe, the expense of non-formal care assigned to the shoulders of dementia patients and their family members reaches one-third of the total cost of care. The difference in this financial investment is not surprising. In Spain, in comparison to most of the countries in Europe, the budget intended for social protection is relatively small compared to other countries in Europe (Farre, et al., 2015).

Aaltonen et al. (2014) broaden the argument. In their opinion, no social or public entity is willing to take upon itself financial responsibility for the elderly dementia patients at the end of their lives, since it is expensive and increases further as the disease progresses. Thus, a caregiver is forced to move the patient to hospital or another institution. Thus, the quality of life and health of the dementia patient is harmed even further. According to the findings of research studies conducted in Finland, about 20% of all dementia patients were hospitalized at least once in the last month of their lives. Furthermore, it was found that one of the most important factors in the number of hospitalizations for the rest of life and the number of transferences among institutions is the caregiving staff. In other words, the high availability of professional and skilled nurses who had training appropriate for the care of dementia patients constitutes a protective factor against the damage to the quality of life of dementia patients at the end of their lives (Aaltonen, et al., 2014; Houttekier, et al., 2014).

Among dementia patients, the quality of life depends directly and fully on the quality of care provided to them, especially as the disease advances. This is a terminal disease that requires a clear program that takes into account a tranquil death. The idea of death with dignity and according to the desires of the patient demonstrates a high quality of care to every person regardless of age and disease. The achievement of a high quality of care at the end of life constitutes a significant challenge for the caregiver since dying from dementia is dissimilar to dying from any other chronic disease. The advanced age of these patients means that their death is not perceived as dramatically as death from cancer. Objectives in quality care rely on the values of the care providers and guidelines used in the care of other chronic patients at the end of life. Setting guidelines suited for care at the end of life of dementia patients may significantly improve the situation of these patients (Tsai, et al., 2015).

For healthy old people, the desired death is quick, painless, private, and if possible, at home. For dementia patients, the reality is different, even at the moment of death. In other words, most elderly dementia patients spend the rest of their lives in institutions without appropriate care and die, not only without dignity but also in pain, without adequate treatment, suffering, and without the minimal privacy deserved in such situations. Caregivers of elderly dementia patients argue that dementia patients who die in their homes receive a higher quality of life at the end of their lives than do those who die in institutions (Olsen, et al., 2016).

Despite the desire of the family members to continue the care of the dementia patient in the home, the progress of the disease does not allow this. One of the strongest predictors of the transfer of dementia patients from the home to the institution, aside from the severity of dementia, is the burnout of the non-formal caregiver, namely the spouse and the children who provide care for the patient. Care without vacations or rest, with the absence of support or economic compensation, causes burnout and continuous and constant harm to the caregiver's mental and physical wellbeing (Farre, et al., 2015; Hazzan, et al., 2016; Philips, 2016). As dementia worsens, the sole caregiver begins to cope with the steadily increasing complexity of the care, with its many tasks that can be very challenging for several caregivers concurrently. Under the heavy burden, which is not suited for one caregiver, there is severe harm to the caregiver's mental and physical wellbeing, which is translated into constant harm to the quality of care. Mental wellbeing is the most important component in the quality of life, as reported by the individual. Therefore, when a caregiver suffers from a lack of mental wellbeing over the long term, his quality of life is impaired. This harm is characterized by the development of chronic illness and the lack of ability to continue to fulfill the role of the caregiver appropriately. It was found that caregivers of dementia patients suffer from severe harm to their mental and physical wellbeing following their role and report a quality of life on a significantly lower level in comparison to the caregivers of patients with another chronic disease, such as, for example, different cancers (Hazzan, et al., 2016).

Harm to the caregivers' wellbeing is not at all surprising. One of the caregiver's main roles is to realize the patient's preferences, especially towards the end of the patient's life. In contrast to other chronic illnesses, such as oncological diseases, the caregiver cannot act according to the patient's interests, since the period of the end of the life is not structured, and dying from dementia may be lengthy and not diagnosed as such. Caregivers of dementia patients tend to make decisions instead of the patients, and frequently they implement their personal preferences and not those of the patients themselves. A caregiver who provides daily care for years to the same patients at the end of their lives naturally may remove emphasis from values that were important to the patient himself. Consequently, when the patient while healthy, before the worsening of the dementia, did not leave written instructions, a caregiver tends to make personal interpretations and to provide care according to his preferences and desires and not according to the patient's interests. Such behavior in the field of care places heavy responsibility on the shoulders of the caregivers of dementia patients and harms their mental wellbeing (Tsai, et al., 2015).

Caregivers of dementia patients are called the 'hidden victims' of dementia, because of the especially high economic, social, and personal cost the caregiver pays when he takes upon himself the care of the dementia patient. Different research studies found that there is a strong relationship between the caregiver's mental wellbeing and the level of quality of the care that he gives his patients and when talking about dementia patients the relationship is even stronger. However, there is an insufficient number of research studies that focus on the nature of the influence of the decline in the caregiver's mental wellbeing on the quality of care he provides to dementia patients. Findings among caregivers of dementia patients link the decline in the caregivers' quality of life to the rise in absences from work and therapy at a low level of quality. In other words, as the caregiver of the dementia patients feels greater harm to the quality of his life and defines it as low following his work as a caregiver, he will tend more to be absent from his workplace and will be less effective within the framework of fulfilling his role when providing care to the patient (Hazzan, et al., 2016).

A caregiver feels a decline in his mood, which over time becomes consistent and continuous, and in the end develops into mental illness (Srivastava, et al., 2016). In addition, the performance of routine daily tasks causes burnout, which detrimentally influences the caregiver's mental and physical health. Burnout has serious implications in the health, social and economic fields, both for the caregivers and for the dementia patients. The burnout from the work is not the only thing that causes negative outcomes. Overload, the multiplicity of tasks and patients, multiplicity of work hours– all these and other factors precede burnout and exacerbate the caregivers' situation. Therefore, improvement in dementia patients' quality of life begins with the understanding of the factors that influence the quality of life, as it is defined by the caregiver. The caregiver of dementia patients, regardless of his closeness to the dementia patient, provides care on a significantly high level when he feels mental wellbeing in his life and defines the quality of life on a high level (Farre, et al., 2015; Hazzan, et al., 2016; Houttekier, et al., 2014). In addition, when a caregiver reports a high feeling of self-efficacy in the care and he believes in his ability to help, the care he provides will lead to more positive outcomes for the patient (Thyrian & Hoffmann, 2012).

The group of elderly dementia patients is a unique group that is unlike other patients with terminal chronic diseases. The caregivers of this population, more than other caregivers, feel extreme burnout as a result of their work. Caregivers of dementia patients, formal and non-formal, suffer from social, mental, and physical burnout. In addition, when talking about a caregiver who is the dementia patient’s spouse or child there is also economic harm (Goren, et al., 2016).

The quality of life of the caregiver and the quality of life of the dementia patient are interrelated and are dramatically influenced by the caregiver’s feeling of burnout. However, it is necessary to take into account objective factors of the advance of dementia. A functional decline and considerable medicinal treatment themselves are defined as factors that harm the quality of life, regardless of the caregivers’ abilities. In addition, dementia patients in the initial stages of the illness maintain that the loss of the ability to recall and make judgments and consequently the end of everyday activities and avoidance of social reciprocal relations cause a sense of decline in the quality of their lives. The considerable physical dependence on another person, a family member, or a stranger, also harms the quality of life. Therefore, it is reasonable to assume that as the dementia runs its course, the dementia patient’s quality of life will be impaired further. Moreover, when two groups of dementia patients are compared, according to their residential arrangement, it is seen that dementia patients who live in their homes have a better quality of life than dementia patients who live in institutions. Therefore, the main goal in the care of dementia patients is to allow them to live in their homes so that they can achieve the best possible quality of life while receiving appropriate care through the creation of good maximal conditions for this on a state-wide level (Olsen et al., 2016). The many transfers of dementia patients at the end of life in combination with the deficient care of their basic needs in institutions for the elderly harm their quality of life at the end of their lives and cause a quick death (Aaltonen, et al., 2014).

The construction of intervention programs for effective treatment of burnout among caregivers improves their quality of life and indirectly enables better care of dementia patients (Srivastava, et al, 2016). In addition, it is recommended that training programs are implemented which are suited to caregivers who will work with the elderly in general and with dementia patients in particular. Knowledge acquired before the significant encounter between the caregiver and the patient creates a basis of understanding and will give the caregiver mental strength. When talking about caregivers who are family members and there is no possibility to train the caregiver ahead of time, a more in-depth and personally adjusted intervention is required (Goren, et al., 2016).

As of today, decision-makers in health systems around the world totally ignore the personal and social costs and take into account only public economic costs, and even those only to a partial extent. In the care of dementia patients in general there are political and economic considerations, although the sole consideration that is supposed to be taken into account is the patient’s wellbeing and quality of life (Farre, et al., 2015; Philips, 2016). To improve the quality of care and consequently the quality of life of dementia patients, it is necessary to build a constellation of support for formal caregivers and family members, while investing the resources necessary on the public level. This program is supposed to be a part of the health policy in the treatment program of these patients. The performance of many more research studies that attempt to understand the nature of the relationship between the caregivers’ mental and physical wellbeing and the quality of care they provide will contribute to the construction of intervention programs that directly and indirectly will lead to better care of dementia patients (Hazzan, et al., 2016; Srivastava, et al., 2016).

In Spain, within the framework of the law for the promotion of personal autonomy, from 2006, protection has been given to an individual found in states of dependence, like dementia patients, although the enforcement of the law is only partial (Farre, et al., 2015). In Germany, too, physicians suffer from an excess of conflicting demands of the health system, the lack of effective tools with which to help dementia patients and their family members, and the lack of agreement among the different caregivers regarding the end-of-life care of dementia patients (Thyrian & Hoffmann, 2012). A similar situation is also found in other countries of Europe. According to the guidelines in Finland, caregivers must provide appropriate care in one place, instead of transferring dementia patients from home to institution and in continuation with the progression of the disease between different institutions. However, in actuality dementia patients at the end of their lives move from place to place, in the search for care that suits them and they die with a low quality of life. To prevent intentional harm to dementia patients' quality of life because of multiple moves, which are sometimes not necessary between residential places, institutions that provide care to dementia patients are supposed to be public and suited to the care of these patients. Further research studies are required to precisely characterize the situation that today is found in its infancy (Aaltonen, et al., 2014; Houttekier, et al., 2014).

2.4. Antonovsky's model of dealing with stress.

To improve the quality of the care of the elderly in general and of dementia patients in particular and in light of the constant rise in the percentage of the elderly in the population, it is necessary to increase the percentage of nurses who are skilled in the care of the elderly and dementia patients. For instance, in Switzerland, to maintain the standard of treatment and to provide an optimal solution for the elderly people's needs, it is necessary to increase the staff of nurses by at least 30%, as long as it is possible to prevent the attrition of the human resource in institutions caring for the elderly (Schwendimann, et al., 2016).

There is no argument about the need for the addition of nurses; however, in parallel, it is necessary to improve the work conditions of the caregivers as an essential condition of the quality of care among the elderly. Today, the working conditions of nurses entail excessive load, tension, multiple hours, work in shifts, and lack of physical safety. Therefore, it is not at all surprising that inappropriate conditions in work cause the rapid burnout of nurses and dissatisfaction with the care that they provide. In addition, there is work for many hours under pressure, great emotional load, and other factors of stress. Nurses and other caregivers exhibit behaviors that endanger their health, cause excess weight, and other diseases, and can adopt for themselves practices that harm their health even further, such as smoking, physical inactivity, and other detrimental habits (Pedrazza, et al., 2016). Different research workers around the world find a relationship between the quality of care and the satisfaction of the caregiving staff. The staff that is satisfied with its work shows this in its work with patients during the care and achieves better health outcomes. Thus, it appears that great satisfaction among the staff of nurses who care for the elderly derives from the feeling of respect that the workplace gives them and thus causes some of them to give their patients care of a high level while placing the patient and his family at the center. In addition, if leadership is defined as effective and respectful, and the staff as supportive, nurses tend to be satisfied with their workplace and the quality of the care that they provide rises significantly, moreover, they report their desire to remain in their workplace. Furthermore, nurses with low satisfaction with their work define the care they give the patients as of low quality and tend to leave the organization in large numbers. In their opinion, the reasons are the lack of skilled and professional personnel, uncooperative and unsupportive staff, and failing leadership. Thus, it is possible to conclude that satisfaction at work among caregivers is influenced primarily by two groups of factors: one is personal factors (such as gender, age, education, physical health, emotional background and so on) and the other is organizational factors (such as leadership, management ability, equipment, and material resources, cooperation in making decisions, advancement opportunities, overload, teamwork, factors of tension at work) (Schwendimann, et al., 2016).

However, some researchers maintain that the problem with caregivers is far more complex than it appears. For instance, 30-65% of physicians report burnout from their work, while the highest percentage of physicians with negative feelings characterizes physicians in internal medicine and most of the work hours are spent at the patient’s bedside, or in other words, they are found at the forefront of the treatment. Organizational factors which cause a lack of satisfaction among caregivers with the work (such as overload, many hours on shifts) are themselves unequivocal causes of caregivers decreasing the quality of care, but as the different research works around the world show, a miserable caregiver (regardless of the reasons for the misery) gives care that is less good than a happy caregiver. In addition, a happy caregiver who is satisfied with his work develops fewer chronic illnesses and his patients are more satisfied with the care they receive in comparison to patients who receive care from a physician who is miserable and frustrated in his life and in his work (Pedrazza, et al., 2016).

Today, most of the health systems in the world suffer from a lack of skilled and professional human resources among caregivers, especially in institutions for the elderly. In addition, different institutions and medical organizations are characterized by limited resources, a high load of patients relative to the number of caregivers, and stress factors entailed by the work. However, there are essential differences in the mental wellbeing of caregivers as defined by the caregivers themselves. Hence, under similar organizational conditions, some caregivers succeed in providing care of a high level of quality following a high level of satisfaction and as such do not succeed in providing a high level of medical service, following the sense of mental wellbeing and low level of satisfaction. Empathetic and skilled therapists, much like any precious resource, are both valuable and finite. Their availability is not limitless; they represent a limited reservoir of care and support that our communities depend on. Today, it is noted that there is no multiplicity of caregivers regarding the patient and the multiplicity of resources. It is expected from every caregiver to provide not only skilled and professional care but also sensitive and compassionate care. Effective coping with stress factors at work and in everyday life on a personal level for every caregiver helps the caregivers achieve mental wellbeing, happiness, and satisfaction while preserving high professional competence in treatment. Thus, an understanding of the ability to cope with stress factors at work and in everyday life among caregivers and the construction of proper intervention will necessarily lead to an improvement in the care of patients of all ages (Pedrazza, et al., 2016).

Research works that investigate the implications of tension and stress on health present statistically reliable findings that stress events cause the appearance of illness. Conversely, some people cope with events of stress and do not develop illnesses. The difference in the manner of coping of different people with similar events of stress led Aaron Antonovsky, who researched stress, to develop a model that may explain and predict the individual’s ability to cope with situations of stress in his life (Sullivan, 1993).

The salutogenic approach focuses on the factors that contribute to physical and mental health at the time of coping with events of stress. For every person, similar events create different levels of stress. In addition, each person has different resources for effective coping with stress. The salutogenic model of Aaron Antonovsky attributes considerable importance to the individual's ability to successfully adjust to stressful events in life and attempts to explain how certain people succeed in continuing to function and maintain their health and ability to cope effectively with exposure to stress, tension, and difficulties (Antonovsky, 1993).

According to this model, the individual can use temporary resources to solve problems in his life if he has the mental and social abilities. In contrast to other approaches that see sickness and health as two separate situations in which the individual is found, the salutogenic approach sees health and sickness on a continuum upon which the person is found at a given moment. The person is the body, thoughts, emotions, personal and social life and constitutes the constellation of aspects. Therefore, the individual's health is a general appearance that addresses the individual's general situation, in all dimensions of his life and not only for his given physical situation (Geyer, 1997). In addition, the presence of factors of stress is universal, and therefore they are found at all places and at all times. In other words, every person lives in a world of tension and stimuli for stress. Stimuli that lead to a life of tension are unavoidable and therefore perceived as routine in the individual's life. However, factors of stress change from person to person according to the personal definitions of different events. Therefore, the strength of the impact of factors of stress on the individual's life depends on the individual himself, his perception, and the interpretations of the events that occur (Antonovsky, 1993). Thus, according to the salutogenic approach, the individual is found at the center of the influence, although the manner of influence on his life (positive or negative) depends on the individual's outlook (Sullivan, 1993).

According to Antonovsky, to understand how the factors of stress influence the individual's health it is necessary to focus on the experience that the individual feels towards the factor of stress itself. The promotion of health, the individual's movement in the positive direction of the influence of stress, depends on the generalized resistance resources (GRRs). The GRRs help the individual cope with the greatest effectiveness with the causes of stress and difficulties during life. These resources include a variety of genetic resources, personal characteristics (such as personal identity), social characteristics (such as socio-economic status, belonging to social groups, and social support), and so on (Geyer, 1997; Sullivan, 1993).

At the center of the salutogenic approach, there is a sense of coherence. This sense, according to Antonovsky, expresses the individual's mental resilience, his perception of his inner and outer world, and his understanding of his life. The individual's mental resilience is the main component in the personality that guides the individual to give the interpretations he gives to different events in his life. Mental resilience motivates the individual to recruit the resources necessary for effective coping with stress. The power of the sense of coherence is not universal. It changes from person to person according to his culture, status in society, personal experience in life, and psychological characteristics (Antonovsky, 1993).

Antonovsky believed that the individual's sense of mental resilience includes three components: comprehensibility, manageability and meaningfulness. Comprehensibility addresses the degree to which the individual's internal and external world are perceived as logical, clear and understood. Manageability addresses the amount of available resources (such as friends and family) that the individual has for effective coping with situations of stress. Meaningfulness addresses the individual's desire to cope with the events of stress in his life. In other words, according to Antonovsky, it is not enough to understand the problem and to prepare the resources necessary for coping. Rather, the individual must have the motivation to use the resources necessary for solving and coping with the factor of stress (Antonovsky, 1993). The three components of a sense of coherence determine the intensity of the feeling. Therefore, people with a high sense of coherence will more easily cope with events of stress in comparison to people with a low sense of coherence. People with a high sense of coherence perceive the world as a clear and logical source, and therefore they feel less anxiety and are less threatened by situations of stress, and their utilization of their resources in coping with these events will be moderate and reasonable. In contrast, people with a low sense of coherence will see stress events (even the mildest) as threatening, will feel extreme anxiety, and will find it difficult to recruit resources and deploy them for effective coping with stress events. Antonovsky describes people with a high sense of coherence as having control in difficult situations; they can help restrain their sensitivity in events of stress and neutralize their destructive impact on their lives (Geyer, 1997; Sullivan C. G., 1993).

One of the main uses of the salutogenic approach is coping with situations of stress in the field of health. Nurses can use the model of Antonovsky to halt the influence of stress in every stage of the care of patients. Because of the intensive reciprocal relations during the treatment between nurses and patients, it is possible to awaken the patient's motivation to the utmost utilization of personal resources to cope with illness as stress and thus not only to minimize the harm to the patient's health but also to create a platform for good health products in the treatment of illness. In the stages of the planning of the nursing intervention, the nurse can identify the patient's factors of resistance and deploy them to cope with the crisis/causes of the illness (Sullivan, 1993).

Illness is considered a situation of stress and crisis for the patient. The care itself and coping with the treatment challenges of certain patients place the caregivers themselves at risk of developing illness in the future. For example, the care of patients with dementia, as with the care for patients with a variety of chronic illnesses, puts before caregivers different challenges. Caregivers of patients with chronic illnesses suffer from different symptoms that are directly related to the level of tension and stress in their lives, such as depression, anxiety, and tiredness. About 74% of caregivers of dementia patients report a significant decline in their health since they began to care for dementia patients. Caregivers with relatively low levels of depression and anxiety displayed high levels of sense of coherence. In addition, these caregivers knew how to more effectively deploy the resources for coping with the stresses that arise in the care of dementia patients. The caregivers who participated in the research saw their family and friends, knowledge and professional help to be central resources in coping with the situations of stress in their work. In addition, for caregivers of dementia patients and the patients themselves, it is recommended to increase social interactions, to cause everyday life to be more meaningful, to increase the experiences and activities that reduce stress and anxiety, and to enable public discourse and social support.

Furthermore, caregivers of dementia patients must receive the opportunity to make themselves heard regarding their feelings and to search for help according to their needs (Pedrazza, et al., 2016).

This chapter delves into the concept of quality of life, specifically from a sociological standpoint. It traces the evolution of the term from earlier notions of standard of living and well-being, highlighting its emergence in the 1940s. The focus of research has shifted towards understanding the social factors that influence individual perceptions of quality of life. Quality of life is inherently subjective, meaning individual experiences and perceptions significantly shape it. However, there's a broad consensus across societies on the factors that generally influence these perceptions. Sociologists identify key areas like economic resources, social support networks, national policies, the environment and personal characteristics as crucial elements. Understanding these factors requires a combined approach, examining both micro-level (individual) and macro-level (social) influences. The chapter emphasizes the importance of studying quality of life within specific groups. For example, caregivers and the elderly face unique challenges and needs that can significantly impact their sense of well-being. For older adults, while aging may bring physical and cognitive decline, the importance of psychological resources and social connections for a positive outlook is highlighted. Erikson's theory of psychosocial development is introduced to demonstrate how successfully resolving life's conflicts can lead to "ego integrity" and a better quality of life in later years.

In conclusion, this chapter underscores the complexity of quality of life, shaped by a dynamic interplay of individual and social factors. By gaining a deeper understanding of these influences, sociologists can play a vital role in improving the overall well-being of individuals and societies as a whole.

3. Patient as an object. Patient as a subject.

In "Man’s Search for Meaning" (2006), Viktor Frankl argues that a person's existence is fueled by three sources: spirituality, freedom and responsibility. Spirituality distinguishes humans from other beings and shapes individual uniqueness, guiding decisions and attitudes even in suffering. Frankl emphasizes that, despite physical and mental stress, a person's awareness remains free. He posits that the search for meaning is fundamental to human survival, a conclusion he reached during his time in a concentration camp. There, he realized that individuals maintain their freedom by choosing their attitudes and finding purpose, which is essential for survival. Frankl asserts that losing meaning leads to despair, while finding it empowers individuals to rise above adversity. He believes everyone has a unique mission in life that cannot be replicated. His concept of spiritual survival transcends mere physical existence, acknowledging that negative emotions are natural in the quest for meaning. Frankl also addresses the existential void, a crisis prompting individuals to seek distraction through activity. He highlights the importance of making choices between action and passivity, desire and obligation, life and death. Each person faces challenges that require them to find meaning and take responsibility for their choices. His logotherapy aims to cultivate this awareness, helping individuals define their life tasks. Frankl warns that many in modern society experience an existential void, shifting aimlessly through life without finding meaning. He emphasizes that true fulfillment comes from an ongoing internal engagement with one's purpose. Additionally, Frankl explores the meaning of suffering. He illustrates this through a conversation with a grieving physician, highlighting that suffering can take on meaning, such as sacrifice. Frankl believes that everything, including suffering and death, holds individual meaning that cannot be universally shared (Frankl, 2006).

3.1. Tracing Goffman’s and Foucault’s connections.

Michel Foucault, in "The Birth of the Clinic" (1994), emphasizes the significance of death in medicine, contrasting with Viktor Frankl's views. Foucault argues that death has its own rules, allowing medicine to dissect bodies and understand illnesses through physiology, anatomy and pathology. He believes that the implications of illness are tied to these biological aspects (Foucault, 1994).

Frankl (2006) asserts that caregivers must actively help patients find meaning in their suffering, which can lead to happiness and recovery. This role is complex, as caregivers also seek meaning in their work. Both Foucault and Frankl highlight the importance of spirituality in caregiving, with Foucault critiquing modern clinical practices for lacking this spiritual connection, reducing patients to mere objects rather than holistic beings (Frankl, 2006).

Foucault notes a shift in the clinical encounter from the 18th to the 19th century, where illness became viewed as a discrete entity rather than a part of the patient's identity. This change led to a more mechanistic view of patients, focusing on their organs rather than their overall well-being. He argues that this clinical approach neglects the personal and social dimensions of patients' lives (Foucault, 1980).

Foucault also discusses the emergence of specialized knowledge and power dynamics in society, where experts define truths that dictate societal norms. He emphasizes that knowledge is intertwined with power, shaping how individuals are perceived and treated within institutions. This creates regimes of truth that exclude marginalized groups from participating in defining societal norms (Foucault, 1980).

In contrast, Carl Rogers (1961) focuses on the individual's personal experience rather than societal structures. He believes that mental health issues arise from the gap between the ideal self and the real self, advocating for unconditional acceptance from caregivers to foster self-fulfillment in patients (Rogers, 1961).

Erving Goffman (1961) explores the dynamics within total institutions, emphasizing the interactions between the institution, inmates and caregivers. He argues that institutions impose strict routines and diminish individuality, leading to a loss of identity for inmates. Goffman highlights the stereotypes and power imbalances between staff and inmates, which can lead to dehumanization (Goffman, 1961).

Overall, both Foucault and Goffman critique the depersonalization in clinical and institutional settings, while Frankl and Rogers emphasize the importance of meaning and personal experience in the caregiving process.

3.2. The attitudes of caregivers regarding care for the elderly and the elderly with dementia.

According to the prevalent definition in the literature, an “attitude” addresses a collection of emotions, beliefs and behaviors regarding a person, object or event. Attitudes are a result of the experiences that individuals accumulate in their lives or a result of the education the individuals receive throughout the process of socialization. An attitude is a complex constellation that influences a variety of areas in the individual’s life, close environment and community. Allport (1935) defined an attitude as “a mental and neural state of readiness, organized through experience, and exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related” (Allport, 1935, p. 810).

This broad definition does not provide an adequate explanation and leaves room for too great an interpretation of an attitude. Therefore, Ajzen and Fishbein (1975) proposed a more focused definition, according to which an attitude is a negative or positive assessment that the person declares about a person, object or phenomenon. They define an attitude as: “a learned predisposition to respond in a consistently favorable or unfavorable manner with respect to a given object" (Ajzen & Fishbein, 1975, p. 6).

The word “object” in the definition of Fishbein and Ajzen addresses topics and people, phenomena and objects. When an attitude is explained through words (such as love or hate, good or evil), it is possible to easily map the individual’s approach towards the phenomenon, person or object. Thus, according to this definition, the individual’s attitude is a personal assessment of a phenomenon or a person influenced solely by personal sources. Almost twenty years later, Eagly and Chaiken (1993) proposed a similar definition, according to which “Attitude is a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor” (Eagly & Chaiken, 1993, p. 1).

From the definitions accepted today, it is possible to learn that attitudes are composed of three components: cognitive, affective and behavioral (Ajzen & Fishbein, 1975). Furthermore, attitudes are influenced directly by the individual’s experience in society and the range of social factors, such as education and learning, patterns of culture, and so on. It is important to note that culture constitutes a meaningful basis for the understanding of attitudes in general and attitudes towards the elderly in particular. When speaking about culture as a basis of attitudes, it is important to take into account the wide variety of factors that influence the culture, such as, for example, modernity and the phenomena connected to it. One of the prominent examples is Eastern culture. On the one hand, at its basis, there is the value of great respect for the elderly, and traditionally families take upon themselves the care of the members who reach old age and/or who need nursing care and assistance with the performance of basic activities in everyday life. On the other hand, the strengthening of the influence of Western culture has caused the creation of significant changes in the values that had been until now the mainstays. Therefore, based on the new values that have been created, young generations are becoming busier day by day with personal matters and are changing the traditionally accepted preferences so that the care of elderly family members is no longer a leading priority. Moreover, the rift between personal preferences and family expectations causes the creation of negative attitudes among the younger generation towards the elderly and the care of elderly family members (Khagi, et al., 2020). Nevertheless, the main assumption is that the family is the only “institution” that can bridge over the deficiencies related to the aging process – whether they are emotional or related to basic existential needs, the organization of daily life, health problems, or social functioning. In the context of the current reality prevalent in the world in general and Polish culture in particular, the most common means of providing care to the elderly is the family. In other words, the most immediate and complete care is usually organized by the elderly person’s closest family members (Luszczynska, 2021).

The phenomenon of the creation of negative attitudes towards old age in general and towards the elderly in particular is a modern phenomenon encompassing the entire world, characterizing most of the countries in the world, and occurring in parallel to the phenomenon of the aging of the population of these countries. The approach towards the elderly changes from country to country. Moreover, it is possible to conclude that the social status of the elderly is higher in countries that cling to tradition, relying on values of showing respect to the elderly, where the value of the family supersedes the value of the individual’s good. Even in traditional societies where the value of the family is high (for example, Turkey), the social perspective on the elderly is changing in contemporary times under the influence of modern phenomena. This change is especially prominent in the background of the transition of society from a patriarchal family, with positive and respectful attitudes towards the elderly, to a nuclear family characterized by negative attitudes towards the elderly accompanied by a lack of respect towards them (Pekince, et al., 2018).

Khagi, et al, (2020) emphasizes, that how the elderly and their families experience aging is influenced by a variety of factors together, such as the attitudes of the younger generations regarding the elderly, the government policies that are established and implemented to support the elderly, the local initiatives carried out in the communities to help the elderly stay active in old age, and also how the elderly themselves see aging and their role in society (Khagi, et al., 2020).

In addition, the aging of the population leads to an increase in the percentage of the elderly who need nursing and medical services. However, this logical demand that is directed towards modern health systems is not satisfied. Today, the health system does not provide an appropriate solution for the needs of the elderly, especially those who need institutions for the rest of their lives, such as the elderly with dementia. Furthermore, such a dramatic increase in the percentage of the elderly not only imposes a burden on health systems but also causes the appearance of different age-related social and cultural problems. These problems contribute to social attitudes of discrimination against the elderly (Hwang & Kim, 2021; Khagi, et al., 2020).

Alongside the process of the aging of the population, there is a natural reduction in the number of caregivers (this is the aging-demographic phenomenon, referring to the increase in the number and percentage of the older population aged 60 and above, and at the same time, the decrease in the number and percentage of the young population aged 15 and below) (Smith, et al., 2022). This decrease, alongside negative social attitudes towards the elderly, has caused the formation of a huge gap between the essence of the caregiver as it should be and the caregiver in reality. Namely, the character qualities, personality and emotional abilities are just as important as the professionalism and skill that nurses acquire in the field of care. Thus, the human capital that cares for the elderly and is found exclusively beside patients' beds, such as nurses, is supposed not only to increase along with the increase in the number of the elderly worldwide but also to have suitable personality attributes. At present, paradoxically, the number of nurses who provide care for the elderly has decreased, despite the efforts of health systems, while there has been an increase in the number of random people who come to the care professions. The complex training and high level of skills required in the care of the elderly population, built on an emotional basis and suitable personal traits of nurses, create a positive approach towards the care of the elderly, enabling the acceptance of aging maturely, and creating positive attitudes that will contribute both to the care of the elderly people themselves and modern society (Smith, et al., 2022).

As is known, most geriatric nurses in their everyday activity care for a large number of elderly people. Therefore, the attitudes of the nurses providing care to the elderly have a decisive influence on the quality of the care the elderly receive, especially those who are found in an institution for the rest of their lives. Logically, the quality of the care is a reflection of the dominant social attitudes that bring them to their activity as nurses. Thus, for example, when an elderly person encounters the care of a nurse with a negative attitude towards old age or the elderly a basis of trust in the care will not be formed. This will harm the quality of the care as well as the caregiving nurses' feelings. A social situation is created in which the caregivers of today develop generally negative social attitudes towards the elderly and therefore convey the same discriminatory attitude found in general society to the health system (Hwang & Kim, 2021; Khagi, et al., 2020).

When speaking about the knowledge and training of nurses and other caregivers, there is consensus among the researchers concerning the importance of the component of knowledge in the acquisition of attitudes by caregivers. Thus, the benefit of nurses with a high level of knowledge and skills in the care of the elderly, and positive attitudes towards the elderly is significantly greater than that of other caregivers. In other words, nurses with relevant knowledge, experience and skills who meet the elderly patients' needs and have positive attitudes towards aging provide care on a high level of quality, as opposed to other caregivers. Moreover, this type of care for the elderly causes a shortening of the period of hospitalization and reduces the number of repeated hospitalizations of the elderly following the same problem (Sedri, et al., 2022). Other researchers concur with this opinion. Smith and colleagues (2022) assert, that designated training creates nurses who are prepared for work with the elderly both emotionally and professionally. However, purely professional training, without the initial emotional preparedness to work with the elderly, will harm the creation of positive attitudes regarding the elderly (Smith, et al., 2022). Thus, the professional knowledge acquired during studies of the care of patients is an important component in the creation of positive attitudes, but it is not exclusive. The most prominent examples are intensive care and emergency room nurses. Nurses in intensive care and emergency rooms have the longest and most complex professional training, but they have the least positive attitudes towards the care of the elderly, compared to other nurses. The difference in attitudes among nurses is influenced not only by knowledge and emotional basis but also by the complexity of the care, the outcomes of the care of the elderly, the speed of the change in the elderly patients' situation, and so on (Sedri, et al., 2022).

However, Sedri et al. (2022) caution that the training of nurses takes time and requires painstaking classification and filtering of candidates for the studies. Despite the undoubted emotional ability of nurses in interpersonal communication, many hold negative attitudes towards the elderly and their care. This phenomenon, according to Sedri et al. (2022), is worrisome. In their opinion, the level of relevant knowledge vital to the care of the elderly among nurses with negative attitudes is low, and therefore they are less prepared to work with the elderly, even if they work with the elderly on a daily basis. Therefore, regardless of the nurses' time of exposure (experience) to elderly people, it is necessary to make certain there is proper, relevant, lengthy and quality training before they are exposed to the care of the elderly (Sedri, et al., 2022). In addition, research carried out in Turkey found that younger nurses (up to five years of professional experience) have more positive attitudes than do more experienced nurses (with professional experience of more than five years). It is possible to explain this through tiredness, exhaustion and an increase in the workload over the years (Pekince, et al., 2018).

Khagi et al. (2020) also found in their research that the training of nurses is a significant factor in the shaping of positive attitudes, and because of the knowledge gained, they will be less dependent on general social attitudes on the topic. Nevertheless, they maintain that training and professional knowledge do not constitute decisive factors in the formation of positive attitudes towards the elderly or the care of the elderly (Khagi, et al., 2020). Topaz (2009) supports the assertion that improvements in the level of knowledge improves attitudes among caregivers. In his opinion, in Israel, in light of the erroneous reference to the topic of healthy aging in nursing studies, nurses suffer from a lack of knowledge on the subject and their higher education does not contribute to their work with the elderly. Consequently, he believes that improvement in the levels of knowledge in gerontology and geriatrics during professional training will contribute unequivocally to the improvement of attitudes towards the elderly in hospitalization wards in hospitals in Israel (Topaz, 2009). Furthermore, an excessively judgmental stance and a view of the elderly as burdens devoid of benefit characterize many caregivers. Thus, not only does a negative attitude towards the elderly become entrenched but also anxieties and fears regarding aging are created in the caregivers themselves. The situation may be even more serious when the caregivers are not aware of their negative attitudes towards the elderly (Hwang & Kim, 2021). According to Sedri et al. (2022), in comparison to the general population and other social groups, nurses’ attitudes range from neutral attitudes to positive ones, because of their experience and their greater exposure to the elderly than the rest of the population (Sedri, et al., 2022). Moreover, when caregivers live with the elderly person, they provide care for, their attitudes towards the care of the elderly are more positive in comparison to caregivers who do not live with the elderly person. When a caregiver lives with an elderly person, the caregiver develops better communication with a healthy elderly person and learns to understand better. The interaction with a close relative who has grown old in front of the caregiver enables the caregiver to see the good sides in aging, which cannot be seen in the care of a sick elderly patient they had not known previously (Pekince, et al., 2018).

According to Illouz (2007), communicative ability is a clear example of an object of knowledge that creates new tools and ways of using knowledge. Communication skills are the ability to interpret the behavior and feelings of others and require a complex coordination of emotional and cognitive skills; thus, the ability to empathize with the point of view of others and with their feelings defines empathy. Empathy for others cannot be developed without deciphering the complex network of signals and signs that people use to reveal themselves or hide themselves during social interaction. Therefore, deciphering the complicated code of the other person's behavior involves an emotional ability that varies from one person to another. Good communication skills require a high degree of self-awareness. The understanding of the self-communication style helps the individual to leave a good impression. The greater the awareness of how others see you, the more easily the individual adapts to communication styles around them. Hence, the understanding of multiple communication styles does not turn a person into a chameleon that adapts itself to the environment but allows the individual to make others feel more comfortable in his company by emphasizing certain behaviors. The person who reaches such a level of emotional skill also acquires the ability to listen – to reflect the intentions and meanings of the other person. This ability not only allows conflicts to be avoided during the interaction but also creates social networks of cooperation (Illouz, 2007).

Like many other researchers, Hwang and Kim (2021) emphasize the great importance of nurses' high level of emotional intelligence. This, in their opinion, contributes to the nurses' efficacy in observing, evaluating and differentiating emotions from one another, neutralizing the negative ones, and effect cognitive and behavioral change during the care of the elderly. Furthermore, the intelligent use of nurses' sense of self-efficacy, empathy, self-regulation, self-motivation and variety of effective tools of interpersonal communication enables them not only to regulate emotions towards the elderly in deed but also to acquire positive attitudes. Thus, in their research study, they found that nurses who frequently meet with the elderly develop positive emotions towards them and have reduced fear of them. In addition, high emotional intelligence among the caregivers of the elderly not only will necessarily improve the quality of the care but will also significantly lessen the level of burnout and tension among the nurses entailed by the difficult tasks of the care (Hwang & Kim, 2021).

A research study that studies institutions for the elderly and examined the attitudes of nurses towards the physical restraint of the elderly found that nurses and aides hold negative attitudes regarding physical restraint (such as tying the hands) of the elderly during care. Despite high levels of knowledge on the topic regarding conditions for physical restraint and maintenance of the safety of elderly patients during the restraint, nurses report their lack of ability to realize the other measures before the beginning of the physical restraint. Thus, the restraint of the elderly person becomes a necessary means in the elderly person's care. According to them, the load and burnout they feel during the simultaneous care of twenty to thirty elderly patients causes them to use physical restraint of the elderly patient not only with great speed but also by skipping over other measures that take time and require individual supervision of the elderly person. In addition, nurses emphasized the internal negative feelings they have following the tying of the elderly patients' hands. They assert that the multiplicity of care tasks leaves them no choice but to restrain the elderly person, to use physical force, to provide the care, and to complete the tasks it entails. Therefore, the nurses and aides see tying as an unavoidable and necessary measure during the care of elderly patients, despite the negative attitudes towards this measure in their work. Furthermore, according to many nurses, many components in the care of the elderly appear to be a systemic constraint and cause ambivalent feelings. In other words, the nurses' general attitudes towards the elderly are good. But when they are required because of systemic failures to adopt measures such as binding hands, their attitude towards the care in this case is negative (Wang, et al., 2022).

When discussing the caregivers' attitudes towards the elderly, it is important to discuss discrimination based on age. Modern society has created the phenomenon of ageism, which is a significant problem in modern society in general and in health systems in particular. Nurses constitute a social group that comes into contact with the elderly at the highest frequency, compared to other caregivers or social groups. This is not surprising at all. The elderly are sick more frequently and need health services more than other social groups. Therefore, many caregivers and medical practitioners express their discriminatory attitude towards the elderly through a disrespectful approach, neglect, condescension, negation of their significance, rejection of vital treatments, and sometimes even violence. Accordingly, the elderly have a feeling of lack of efficacy, loneliness, and social distancing because of the lack of meaning in their lives in society (Pekince, et al., 2018).

It is important to note that loneliness in old age is one of the most difficult experiences entailed by the aging process and that these feelings are intensified especially in situations in which the elderly person, due to his physical disability, lives independently without help and support. One of the most effective solutions to deal with the phenomenon of loneliness is to build a close social network of family or friends. But this is a process lasting many years. Among the elderly, the proportion of single people is the highest, compared to other age groups. Thus, for example, among the population of Poland over the age of 65, approximately 49% of the elderly are single, and among the elderly over the age of 80, the proportion of singles rises to 70.5% (Luszczynska, 2021).

The situation in Israel is similar to the rest of the countries of the West. The life span in Israel today is eighty years in the general population. The aging of the population in Israel is accompanied by a steadily increasing burden on the health system. About 34% of all those hospitalized are elderly, and this percentage is steadily increasing. Other social-cultural phenomena accompany aging. One of the main ones is age-based discrimination or ageism. Research carried out in Israel on the topic of nurses' attitudes towards the elderly has found that attitudes are in general positive and in contrast to nurses in other Western countries nurses in Israel have more positive attitudes toward the elderly (Topaz, 2009).

In addition, according to researchers from Israel, the influence of the sociodemographic and occupational factors on the attitudes of nurses in Israel is negligible and therefore meaningless in this research. This is unlike the research studies carried out in Europe (Topaz, 2009). According to them, women hold more positive attitudes than men and there is great meaning to work experience in the creation of attitudes among nurses. Unlike nurses in Turkey, for example, the attitudes of nurses towards the elderly in Israel do not change over time and the acquisition of additional experience does not change the situation (Pekince, et al., 2018).

It is important to note that in the past decade, to the best of my knowledge, research studies that were carried out (if they were carried out at all) in Israel regarding opinions or attitudes among caregivers towards the elderly or their care have not been published. Thus, it is possible to conclude that there are gaps in knowledge that require research studies to be conducted to fill these gaps.

3.3. Caregiver's self-presentation through social roles.

Erving Goffman (1959) believed that the presenting of the self takes place in a theatrical-dramaturgical manner. His approach is useful for understanding how individuals present themselves and their behavior to others in different situations. In his opinion, individuals create the impressions experienced by those around them. Furthermore, individuals constantly criticize their actions, or lack of actions, especially when they are surrounded by many people observing their behavior. According to Goffman, society is a theater and people are actors on stage. In this sense, the actors (individuals) wear masks that allow them to present themselves to those around them in the manner they desire. That is to say, what takes place on stage is a calculated pretense created by a collection of details that form a specific situation. In the theater, there are three main roles: two of them on stage, represented by actors who come into contact while performing, and the third is the audience watching the play. In real life, these three roles are reduced to two. The part acted by one individual is adapted to the roles that other actors play, and the rest of the people present, or act as other actors as well as an audience (Goffman, 1959).

Ralph Linton, on the other hand, in his "Study of Man" argues that an individual's pretense in society - the social game, is not something that individuals can control. That is to say, pretense stems from the expectations of society and individuals fulfill these roles. It is society that shapes the individual’s behaviors. During their lifetime, individuals play a variety of social roles, some stem from an innate component, like being male or female or belonging to a particular family, and some are acquired, like profession. The society in which these interactions take place creates a particular base perception that defines expectations, duties, and rights involved in the role of the performer. In this sense, the fulfillment of social roles by individuals gives them a certain social status (Linton, 1936). Historically, social roles were designated based on gender: men were employed outside the household, as opposed to women who exclusively dealt with housework and care for family members. This means that men were expected to provide for the family and women to care for it - particularly for the elderly and children. That being said, modern society has brought with it many changes. One of these is a blurring of the distinction between gender roles within the family (Luszczynska, 2021). Today, women are employed outside of the household for pay and men take on some of the roles within their homes. Nevertheless, despite considerable changes that have taken place in modern society, for the most part, women's roles remain traditional, as most of the tasks in the household are still performed by women, regardless of whether they are employed or not. Furthermore, when women work outside the home, the roles offered to them by society are almost identical to those they are expected to perform within the private household: caring for the elderly, caring for the sick, kitchen work, secretarial work, etc. At the same time, changes in the definitions of social roles have led men to take on some of the household chores and in some cases work less outside of the home. That being said, according to Joseph et al. (2018), in most cases, the change in society in this sense is very superficial. Although men do offer help within the household, they do not lead the household chores as women do (Joseph, et al., 2018). Other scholars agree with this claim, pointing out that despite the changes that have taken place in modern society, real changes regarding the definitions of social roles have not yet occurred. According to Smith et al. (2020), the determining factor in preserving the traditional definition of social roles is gender. For example, men make up 49% of the total U.S. population, but only about 9.7% of them are employed in a field that is regarded as a female profession, such as nursing. Although more and more men are being employed in caring professions, the public seeking treatment still expects to be treated by women rather than men. Midwifery is one of the most prominent examples of this. In this area, the proportion of men to date is still close to zero (Smith, et al., 2020).

As expected, a society's healthcare system reflects its overall character. Talcott Parsons (1951) argued that, in their interaction, patients and physicians act according to the social expectations reflected in these roles in the medical-health arena. That is to say, the physician and patient act according to social expectations defined by society, and the two roles complement each other during the interaction. The patient's role is to want to recover and do everything in their power to achieve this goal. Additionally, they are expected to cut down on normal activity and show society their efforts towards achieving a state of health. The role of the physician complements that of the patient. Physicians are expected to bring all of their professional knowledge and skills into the interaction for the benefit of the patients. Additionally, doctors must have only one goal-restoring the patient’s health, that is, the success of the treatment that the doctor offers the patient - who takes a more passive role. For patients to recover, doctors must know, if necessary, intimate details of their lives, perform intimate physical examinations and use this to the benefit of the patients. At the same time, physicians must remain emotionally distant from a patient to be able to perform their duties toward other patients as well (Parsons, 1951).

By regarding men as more decisive and women as more sensitive, society expects men to be doctors (make decisions, give instructions) and women to be nurses (caring, emotionally embracing). In this context, some scholars believe that the difference in the manner of fulfilling social roles stems from gender affiliation. A study conducted in the United States shows that differences between men and women as caregivers stem from the different definitions of sociocultural values regarding men and women. The participants in the study expressed the belief that a reasonable (average) man has lower emotional intelligence than a woman, and, as expected, due to social pressure to "act like a man" will avoid choosing care-oriented professions defined as feminine (such as nursing) and will prefer to belong to a category of healthcare professions that are defined as masculine (such as medicine). Thus, men constitute a minority in caring professions, despite the physical difficulty that this work entails. Furthermore, despite changes occurring in modern Western society, men working in care-related roles in the healthcare system are regarded as an anomaly and even deviant, due to their choices, which go against public expectations. Even men who have chosen to care for patients privately for pay feel uncomfortable as caregivers. They report a hostile and discriminatory attitude, not only from society as a whole but even from female colleagues, who often underestimate male nurses and create a similar attitude towards them among the patients. In addition to this, research shows that men report considerable difficulty in working as a male nurse within a team of (female) nurses. They report social exclusion, contempt, questioning of their professional ability, etc. Similarly, women caregivers also doubt men's ability to offer emotional care and view men acting as nurses as the "elephant in the room" (Smith, et al., 2020, p. 1216). Thus, social expectations regarding previously accepted gender behavior, gender stereotypes, and focusing on gender differences as the most important factor in professional success, in addition to other factors, harm not only the individual but society as a whole. The social stigma, according to which a man should be a doctor and a woman a nurse, preserves inequality in society and limits the well-being and success of individuals and society in general. Smith et al. (2020) believe that even if men offer care differently than women do, it does not mean that men are incapable of treating/belonging to a care-oriented profession. The undermining of gender stereotypes in a modern Western society will allow for a focus on talent, abilities and other professional qualities, rather than gender and additional background data that are irrelevant to achieving vital social goals (Smith, et al., 2020). It follows then, that any caregivers, regardless of their gender, can offer tailored and professional care to patients. This ability stems from personal qualities, experience, skills and professionalism and not from gender as a decisive factor. Converso et al. (2020) also believe that gender has no decisive influence on the ability to offer patient care. As the caregiver's emotional detachment and mental distance from patient care become palpable, the multiplicity of social roles carried out by the caregiver must be mapped out. The conflict in the fulfillment of roles may stem from a multiplicity of conflicting social demands directed at that person and not necessarily from being a male in a female profession or the other way around. An imbalance between the demands of society from the caregiver and the personal demands and self-expectations of individuals takes a high personal and social toll on the caregiver, the patients and the society in which the interaction takes place. Thus, the aging of the general population, complex intergenerational family processes, the reduction in family size, the multiplicity of social roles taken on by caregivers in various ways, etc. - intensify personal conflicts for caregivers and create not only a lack of emotional involvement, but emotional alienation which may harm the quality of care (Converso, et al., 2020).

Despite a variety of factors influencing self-presentation, Goffman believed that an individual's self-presentation was under their control, albeit led by expectations of others regarding the role that they decided to play. Goffman expanded on this claim, and in his work on self-presentation wrote:

> "When an individual enters the presence of others, they commonly seek to acquire information about him or to bring into play information about him already possessed. They will be interested in his general socio-economic status, his conception of self, his attitude toward them, his competence, his trustworthiness, etc." (Goffman, 1959, p. 1)

That is, information about the individual helps to define a situation and allows others to know in advance what the individual expects of them and what they can expect from the individual. In this way, the individuals' social group knows how to act in the best way to get the desired response on their part. If those around them do not know the individuals, they can compare them to someone similar who has been in this environment before, but in any case, usually, those around the individuals are quick to create or apply common social stereotypes about them. Additionally, they can judge a new individual according to their experience, since individuals of a certain type may be more likely to enter into a particular social environment. Furthermore, those constituting the individuals' social group can rely on the things the individuals choose to say about themselves to others as well as documents that the individuals choose to present. When the individuals are familiar to others and the group has heard of them before their arrival, it will choose to rely on hypotheses relating to the individual's psychological characteristics. These hypotheses will serve the group as a means of predicting behavior in an interaction in the present and the future (Goffman, 1959).

Under the influence of Goffman, Illouz (2007) believes that in the situation of a face-to-face meeting, a feeling arises that people are close enough to be able to note what each other are doing. Hence it is evident that interaction is a delicate process of adjusting the way people speak and behave to the way they perceive the other person's presence. Face-to-face meetings like these result in a special type of reciprocity. In Illouz's opinion, Goffman means here a form of practical knowledge about social contacts, which does not correspond to the cognitive knowledge of the people in society (Illouz, 2007).

According to Linton (1936), the individual’s social group is directed toward a perceived status and not toward the individual as a person. That is to say, the individuals are accepted by certain groups or rejected by them according to their social status. The evaluation of the individual by those around him or her begins with his or her position on the sequence of values in the given society. The individual is treated with respect or contempt, acceptance or rejection depending on the prestige associated with the individual's status in society. The salient symbols of the significant perceived social status in society may be anything worthy of respect in the eyes of society. For example: type of car, location of residence, salary, access to sources of information, size of apartment, amount of books, ownership of certain properties, friendship with celebrities, etc. (Linton, 1936). Like Linton, modern scholars believe that social expectations create a certain reality for every person in society. Being a nurse comes with obligations. Nursing is a profession that is traditionally identified in society with many years of education, a code of ethics, reliability, self-confidence, professionalism, a balanced mental state, etc. For this reason, modern expectations in society towards women who play the role of a nurse are not at all surprising. That is, a nurse is perceived as a role model as social expectations dictate nurses’ behavior, dress and appearance, even outside of their workplace. A study surveying nurses found that most nurses (74%) feel that being healthy and showing healthy habits is their social duty. Women who have taken on the role of nurse try to meet public expectations. For example, smoking among caregivers is perceived as unacceptable behavior. Thus, when caregivers who smoke advise their patients to quit smoking, they will be met with contempt, disrespect and ridicule (Wills, et al., 2019). U.S. researchers have presented similar data. The public expects to see a woman as a nurse rather than a man and when this expectation is not met social interaction may not take place (Smith, et al., 2020).

In his work, Linton (1936) introduced the physician as a caregiver whose status in society is high by belonging to the male gender and he believed that a woman in the same role would be valued less by society (Linton, 1936). Moreover, modern society has defined some professions as purely female, such as nursing. Therefore, in the eyes of society, when a profession was defined as female, its value decreased significantly compared to male professions. But men also pay the social price in this context. Society has almost completely blocked their entry into professions defined as female (Zufiaurre & Perez de Villarreal, 2008; Smith, et al., 2020). Additionally, the initial data that establishes social assessment depends directly on the gender of the individual and not on the other data regarding status. According to them, "To be well prepared and educated, or to have the right, does not mean that we all have the same opportunities." (Zufiaurre & Perez de Villarreal, 2008, p. 204).

That is to say, men and women with the same social background, similar education, experience, and the same skill level are not provided with the same social opportunities. The option of leaving the home for paid work gave women in a patriarchal society the impression that today anything is possible. But even if women take on the same roles as men, they are certainly less valued. In this context, social changes for the benefit of women in modern society not only did not contribute to their presented image in society but brought with it additional new difficulties regarding their private lives that led to economic crises and the lowering of living standards. Changes in society brought with them new responsibilities and an increase in additional duties that a modern woman is responsible for in addition to her traditional duties (Zufiaurre & Perez de Villarreal, 2008). The perception that social interaction is unreliable is not new. Goffman (1959) saw social interaction as something created in a completely artificial way. For him, every social interaction greatly resembled stage acting. In this sense, any communication between people in society is a pretense. This openly displays the desired perception which is usually not authentic and unrelated to reality. The true attitudes, beliefs and feelings of the individual can be revealed only indirectly and not by direct observation. That is to say, the true face of individuals can be seen through their involuntary behavior and declarations. Many important facts about the individual are not usually visible at the time of the interaction or exist beyond the time and place of the interaction. Information transmitted by the individual may be unreliable and therefore contains only initial validity. The individual intentionally transmits incorrect information by deception and pretense (Goffman, 1959).

In other words, when two people meet, they transmit two types of information to each other: the first is information that they hand over voluntarily and the other is information that they “give away” against their will. According to Illouz, Goffman maintained that in a real meeting, the information that people reveal plays a decisive role, and not the information that they give of their own free will. The information that people reveal about themselves while trying to hide it, depends to a large extent on how people use their bodies (their voices, their eyes, their body positions, etc.), and therefore a significant part of the social interactions between people are a kind of “give and take” between what is under people’s conscious control and what is out of their control. In other words, if in real encounters there is a gap between what people say or how they want to present themselves and what is not under their control, this gap makes it more difficult for people to describe the important characteristics in words. The things that people are aware of are those that generally leave the main impression on the person who is met (Illouz, 2007).

From the individuals’ point of view, there is an interest in monitoring the behavior of those around them, as well as their attitude towards them, regardless of their purpose in the social encounter or their real motives. The monitoring of individuals is affected by the definition of their position by others at any given moment. The individual can influence the situation by presenting himself or herself in a way that will make others act in a certain way. Thus, when individuals are in the presence of others, they will try to create an impression that suits their interests. Sometimes individuals act in a completely calculated way to create the desired impression, even a false one, but sometimes they will be calculated in their behavior without being aware of it. When individuals define a particular reality as effective, it means that they have made the desired impression successfully (Goffman, 1959).

Additionally, in Linton's (1936) opinion, the individual does not act out of individual motives but within his or her social status. That is, everyone who belongs to a society holds a certain status with behaviors/roles associated with class. Naturally, the categorization into status by people belonging to society creates a social system that preserves itself. Thus, the individual will want to maintain his or her status (or achieve a higher status), to continue and belong to society. Activating behaviors defined as an integral part of certain roles within the status, shows those around them that they are fulfilling the roles in the way that society expects and demands. Thus, the individual retains her or his right to belong to society and enjoy the benefits of that social status (Linton, 1936).

When individuals impose a definition of a situation upon entering a new environment, those around them, who were defined as passive by Goffman, also effectively impose their definition of a situation through their behaviors toward them and their reactions regarding their behavior. Most often, definitions of a given situation by different participants are adjusted to each other and there is no visible contradiction between them. At the same time, there is a lack of complete agreement in the case of these definitions, since there is no situation in which an individual honestly expresses what he or she feels and fully agrees with the feelings that others express. So, this ideal picture, according to which there is peace and no struggles, is not real. In practice, every participant in the social encounter is expected to not only suppress his or her feelings but to create such a worldview that will be accepted by others, at least temporarily. The outcome is then that a consensus is possible when all participants compromise on a general definition that does not constitute true agreement. Admittedly, this consent, even if not real, contributes to the prevention of conflicts in social interaction (Goffman, 1959). The situation is similar in the health arena. Society sees caregivers as role models in all areas related to medicine and health. As expected, nurses, as caregivers, try to adopt a healthy lifestyle. Additionally, it is expected that the nurse will not only have a healthy lifestyle but will be at what is considered a healthy weight and will not smoke. A healthy lifestyle, a healthy weight, a lack of smoking, all of these, and more are key values that characterize nurses in society. Therefore, when a nurse smokes or is significantly overweight it is perceived as a violation of society's values and inappropriate behavior on the part of the nurse (Wills, et al., 2019). The explanation for this phenomenon can be found in Linton’s work (1936). According to him, culture in society is divided into two levels, the visible - "external" and the invisible - "internal". The visible is characterized by a variety of individual behaviors that can be observed by those surrounding the individual. The invisible are the attitudes of the individuals, their feelings, and their true values, according to which they conduct themselves in daily life. The two sit at the base of culture in every society known to mankind and constitute a necessary condition for the beginning of any interaction (Linton, 1936). Thus, not only does society require health care professionals to look a certain way and practice healthy behavior, but young women themselves in choosing nursing as their occupation, highlight the traits and behaviors expected of a nurse by society, such as: dressing modestly, having a healthy lifestyle and not smoking. On the other hand, they hide behaviors and/or traits that are not identified in society with the nursing profession. Thus, it seems that the creation of an initial impression is based on social expectations known to women who turn to the profession (Joseph, et al., 2018).

Goffman emphasized the importance of the first impression (initial information) in any social interaction. In Goffman's opinion, when the individual feels that he or she has not defined the situation effectively, they will feel ashamed and those around them will feel hostility towards him. Thus, following the performance of the individual, everyone will feel uncomfortable in the following social gathering. Another difficulty is revealed when to be accepted by others and gain their trust, the individuals openly indicate to those around them that they have certain social characteristics when in practice this is not true. In such a situation, conflict is created between the individual and others even at an initial social encounter (Goffman, 1959). A study conducted among nurses in England supports this idea. According to its findings, when preparing for a meeting with a nurse, the participants expected her to have a certain appearance – to be thin, well dressed, have a pleasant demeanor, etc. When the expected personal representation does not meet accepted public conventions regarding caregivers, dissonance is created. Thus, a nurse who is overweight or not meticulously dressed causes her patients a lack of trust in her ability to perform her work as required. The conflict created in the interaction in the health arena not only harms the effectiveness of communication, but carries negative health consequences in the context of the treatment (Wills, et al., 2019).

An unreliable performance in front of others is not the only conflict that exists in interaction. Another conflict that arises is at the level of the individuals themselves. The conflict is created as a result of a conflict between the various roles that the individuals perform within the framework of the social status to which they belong.

According to Linton (1936), these roles are dynamic aspects of social status. Thus, throughout an individual's life, a variety of conflicts arise following the change of roles in status (Linton, 1936). Similar findings emerge from a study conducted in Italy. Modern caregivers are subject to particularly high levels of burnout as a result of their job requirements. This phenomenon is not at all surprising. The modern caregiver performs similar work within her or his home as well. About 40% of the formal caregivers care for the elderly and/or children in their family in addition to the formal care they provide in institutions and hospitals. Most of them work long hours in hard physical and mental conditions and report a lack of mental well-being, fatigue and high levels of stress (Converso, et al., 2020). Some researchers emphasize that conflict between home and work is more characteristic of women than men. This is due to a traditional definition of the role of women in modern society. High social expectations with multiple demands on women in modern society create a great deal of tension between their paid work and home. Failure to find a balance between them harms not only the family but society as a whole. According to Joseph et al. (2018), modern society does not allow for such a balance, and therefore combining career and family poses a significant challenge for physicians and caregivers (Joseph, et al., 2018). This finding is not at all surprising. The explanation for this was given as early as 1936 by Linton. Traditional medical professions are characterized by long hours, work on holidays and weekends, and boundless giving to the patients, alongside disregarding personal needs and neglecting family commitments (Linton, 1936). A traditional social definition of the role of women, which continues to exist in modern society, makes the combination of a woman's household duties and the requirements of her medical profession impossible. Thus, a woman in a medical role is expected to face a career-home conflict. Women who participated in the study spoke of their sense of inability to meet the various needs of children, partners and other family members. However, improving communication in the modern world (like WhatsApp, messaging, and video communication) can bridge some of the tensions with family. At the same time, the physical presence in the house is lacking despite currently available communication channels. That being said, with the traditional definitions of the role of women, that are still relevant, a modern woman can choose more comfortable occupations in terms of working hours. Thus, women who choose to be paid caregivers can balance their home and career priorities. In addition to this, the relative ease of housework, help that can be paid for outside the household and more, allow modern women to combine many roles with better success than in the past (Joseph, et al., 2018). Other researchers also disagree with the claim that the multiplicity of roles in itself creates stress and harms the quality of life and quality of care. There is no doubt that an internal conflict created in fulfilling many roles at once can result in unstable mental well-being and a decrease in the mental and physical health of caregivers, but in their work studying nurses, participants caring for children and with a joint household/family and many hours at work expressed satisfaction and fulfillment in their lives at a higher level than others who did not take on additional social roles. So, it seems that multi-roles combined with complex caregiver work are a protective factor against professional burnout and depression. That is to say, a rich private life, alongside the hard work of a caregiver, contributes to nurses' stable mental health (Converso, et al., 2020).

Gender inequality in society, which is reflected in the health professions even today, hurts both women and men. It is important to note that the consequences of inequality in the healthcare system are more destructive. When the health care system, due to social influences, selects caregivers based on gender rather than traits that the caregiver's profession requires, it harms the quality of care and well-being of patients and caregivers alike. As long as gender sits at the foundation of care professions the healthcare system will suffer not only from a shortage of caregivers but also from random people filling positions in this profession without the personal qualities required for patient care (Zufiaurre & Perez de Villarreal, 2008).

3.4. Stigmatizing patients with dementia.

The Greeks attributed great importance to visible external markers; they considered visible physical differences not only as unusual but as a bad sign. Such an attitude towards visible difference brought about the creation of stigma. The "bad sign" (the difference), is a situation in which an individual is not considered someone who deserves to belong or to be accepted due to a feature that is defined as different from the rest of society. This occurs because the majority of society defines itself as normal, aiming to create definitions of "abnormal" and rejecting those who do not fit in (Goffman, 1986).

Minorities, homosexuals, the mentally ill and the disabled - all have one common characteristic: they are different, and they are described as "deficient". For this reason, they are exposed to the danger of not being perceived as human by the majority which defines the norm (Goffman, Stigma: notes on the management of spoiled identity, 1986). In his work, Erving Goffman (1986) defined the concept of "stigma" and provided guidelines for analyzing this social phenomenon. According to Goffman, a stigma is an attitude that reduces its object from a unique and complete person to a besmirched and disregarded person. This is "the process by which the reaction of others spoils normal identity" (Goffman, 1986, p. 2). Simply put, a stigma is an individual's psychosocial response to a person or group of people who have traits or characteristics that are not defined as normal by society and who, as a result, experience social marginalization or rejection (Zimmerman, et al., 2016).

Also, old age is associated with the concept of death naturally following the chronological closeness of the elderly to the end of life. The elderly are a group of people who on the one hand prove to society the fact of the existence of death. On the other hand, because of their closeness to death, the elderly make themselves victims of both social distancing and self-distancing. Exclusion, the disappearance of individuals and groups – this is the social understanding of the existence of death. Thus, old age is inextricably linked with death and mortality. It is frequently characterized as the last stage of life, the limit, the unequivocal end. In addition, stereotypes about the elderly concern their health, social usefulness, mental abilities, resourcefulness, appearance, behavior, and rights and expectations towards them. Thus, the elderly are denied the right to be mistaken or ignorant about contemporary technologies, to dress in a certain way, or to talk about their needs, including sexual needs. This stereotype is successfully preserved by the community and transmitted during socialization by family and other people from the environment, such as educators, politicians, religious leaders, the media and elderly people around them (Luszczynska, 2021).

In his classic work on social stigma, Goffman argued that society provides its members with a means of sorting individuals into categories while emphasizing normalcy and what is considered natural for each category. Thus, when strangers face society, their particular qualities can indicate that they are different from others and they are perceived as weak, dangerous or negative. As a result, society perceives different individuals as transitioning from normal and complete beings into vilified, less valued and suspicious threats. Such an attitude, according to Goffman, is a stigma, especially when the individual's opinion is affected. When this happens, people who define themselves as normal attribute difference to disadvantage, defect and disability. This difference is attached to lower social status and characterized as strange by the norm. Rejecting a particular personal characteristic is completely artificial and serves the needs of society. Thus, numerous judgments as to what is considered professional, normal and aesthetic are determined by society on a cultural basis (Goffman1986).

The values and norms which are determined include standards for various social phenomena such as "beauty", "ugliness", "proper behavior", "danger", etc. These ideas are carefully maintained by various social institutions (Goffman, 1986). According to Goffman, stigma is caused by a striking physical difference, a personality defect, and belonging to socially rejected groups. Furthermore, stigma highlights the difference between attitudes and the construction of a stereotyped system. Bruce Link and Joe Phelan extend this argument. They believe that stigma exists when individuals are identified based on a label that separates them from the rest of society and links them to a rejected stereotype that leads to unfair and discriminatory treatment (Link & Phelan, 2006). The two argue that stigma is created as a result of four constant social processes. Firstly, people recognize and label differences and prominent characteristic variances among themselves. Secondly, cultural beliefs tie people with an unwanted trait/difference to a negative set of stereotypes. During the third step, the separation between "us" and "them" is achieved, based on the labeling of these individuals as part of despised groups. In the fourth and final stage of stigma, labeled individuals lose their social status and experience discrimination. According to scholars, all of these components of stigma are relative. For this reason, strong negative traits create stronger social stigma than traits that create a lower level of social aversion. Characteristics that are perceived as negative by a certain society constitute a broad spectrum of different situations. One of these is an individual's illness (Link & Phelan, 2006). Some 70 years ago, Talcott Parsons, claimed that society also considers illness abnormal. He provided an initial model of the patient's role in society. Parsons argued that this was a deviation from social expectations and defined four levels of social expectations regarding "the patient's role" (Parsons, 1951).

First, the patients are relatively exempt from accepting responsibility for the nature and severity of their illness. According to another set of expectations, the patients cannot be cured by willpower alone and are not responsible for their illness. On another level, the illness is not desirable, so the individuals are responsible for performing activities that bring about their recovery as soon as possible. According to another set of expectations, society believes that patients should not only seek appropriate help on the road to recovery (contact a physician for example) but should actively participate in the recovery efforts (Parsons, 1951).

According to Parsons's critics, this model is more suited to temporary conditions of illness with varying degrees of severity. Thus, in chronic illnesses, such as mental illness, Parsons's model is hardly applicable. That being said, it is impossible to ignore the crucial importance that the model has attributed to the caregiver-patient relationship which is at the center of social order (Parsons, 1951). Additionally, illness is not only an individual's bio-physiological condition but a social phenomenon with far-reaching consequences for both the patient and caregiver (Heidarnia & Heidarnia, 2016). In his book "Intoxicated by my Illness", Anatole Broyard examines the role of the physician in a caregiver-patient system from his perspective as a terminal cancer patient and considers the caregiver–patient interaction as a complete social unit. According to Broyard, the two are actors on one stage in a common and important situation for both (Broyard, 1993).

Susan Sontag also examined the reciprocal relationship between the physician and the patient. In her opinion, European and Japanese physicians still prefer regarding the diagnosis of serious illnesses to inform the family members and not the patient himself, and thus they prevent the patient’s active role in his illness. People ascribe too much meaning to illnesses, both physicians and patients. The illness is not a punishment and is not shameful; it is not a sentence or a gift. The illness has no meaning or significance. Even when referring to diseases such as cancer or any other terminal illness, this is a situation in which a person is found at a certain time point on his life continuum, and there is no supreme or concealed meaning in his situation that he needs to search for or understand. Therefore, the physician and the patient in the health encounter are supposed to be free of fears and anxieties about speaking about the illness; they ought to hold the meeting without searching for meanings for the illness that do not exist. They need to speak directly about the topic, without mediators, such as family members, and without thoughts that are not relevant to the created situation. Sontag encouraged patients to initiate the direct encounter instead of active avoidance. She wrote, "Get the doctors to tell you the truth; be an informed, active patient; find yourself treatment, because good treatment does exist (amid the widespread ineptitude)." (Sontag, 1989, p. 15).

According to Sontag, the feelings of guilt and shame because of an illness with which patients and their caregivers are dealing causes the two groups to conceal it from the patient or family members or at least not to create open reciprocal relationships on this topic. It is as if the disease remains a black stain on the patient's life and also endangers the integrity of the caregiver's life (Sontag, 1989).

Various thinkers have linked the state of illness and disease to social stigma. For example, according to Susan Sontag (1978), the importance attributed by society to any perceived illness whose causes are unclear and treatment ineffective tends to be exaggerated. In Sontag's opinion, the most frightening attributes on which stigma is built (such as distortion, decay, infection and weakness) are related to the disease and the disease itself becomes a metaphor. As a result, in the name of the disease (that is, using it as a metaphor), horror is projected onto other elements. The disease becomes an adjective, just like the use of the terms repulsive or ugly. Sontag continued to argue that any illness that is accompanied by a sufficient amount of mystery and fear is considered morally contagious. Hence, a great many people with cancer find themselves distanced from their families and friends and cancer patients are disinfected by their family as if cancer is a contagious disease. Additionally, during certain periods in time, some illnesses were considered a reflection of good or bad character, a product of strong or weak willpower, or even a punishment for immoral behavior. Some social situations can take on the role of super-stigma, define a person, and belittle traits that are related to the matter. A health-related super-stigma is evident when it is mentioned inadequately and freely in inappropriate contexts. According to Sontag, key examples of super-stigma in Western societies are the labeling of homosexuals, mental illnesses, and cancer (Sontag, 1978).

As opposed to these ideas, Broyard emphasized in his book the positive aspects of his terminal illness. Thanks to social isolation due to cancer, Broyard could fully express himself without fear of ostracism, humiliation or discrimination. Broyard claimed that he himself had become "sickness" (the disease) with special powers over a system of doctors who feared him (i.e. the terminal illness he was diagnosed with) (Broyard, 1993).

Unlike Broyard, while describing Dementia, Martina Zimmermann (2017) fails to see the positive aspect of terminal illness. For seniors with dementia, this is a journey from which they never return, a road that never ends - a journey of self-destruction and self-denial. The only positive in the shadow of dementia is the possibility of living in the moment and rejoicing in every little memory before forgetfulness takes over completely. For its patients, dementia has been described as a perpetual "biological war" and a "holocaust of the brain" (Zimmermann, 2017, p. 80).

Furthermore, in his classic book "Stigma", Goffman demonstrated how stigmas create a questioning of an individual's status, as well as shame and disgrace directed at him that lead to stigma. That is to say, those whose stigma is visible experience an immediate adverse effect on their social status. In contrast, those with a stigma (an embarrassing trait) that cannot be seen in ordinary and everyday interactions do not experience any harm to their social status until the stigma is exposed and becomes visible or known. According to Goffman, when the trait that causes stigma cannot be seen, controlling the information can become a major life issue. Goffman described the crucial importance of controlling knowledge about a defect, disability or embarrassing trait. Those who know the answers to the questions "to display or not to display, to tell or not to tell, to let on or not to let on, to lie or not to lie, and in each case, to whom, how, when and where" become completely in control of social interaction (Goffman, 1986, p. 42).

According to Illouz (2007), this concerns not only the understanding of the specialness of certain groups in society and the ability to conceal or reveal it. She maintains that modern society has made emotional skill an official criterion for progress in life and the promotion of personal interests. Thus, emotional capital in its different forms can be translated not only into personal benefit but also into financial values. In her book, Cold Intimacies: The Making of Emotional Capitalism, she provides an example of sales agents who based on certain emotional skills succeeded in selling far more than those who sold traditionally without the use of emotional skill. Thus, the ability to control emotional skills enables control of the information and the impression created in social interaction (Illouz, 2007).

Dementia is one of the examples of super-stigma that can be used to define a person if the disease is publicly exposed. Thus, it is not at all surprising that families of dementia patients and dementia patients themselves face the dilemma of disclosing their illness or keeping it a secret (Heidarnia & Heidarnia, 2016; Zimmerman, et al., 2016). Broyard (1993) saw his terminal illness as a key to self-liberation that pushed him to self-expression for which he would have never had the courage without his terminal illness. In his book, he identifies himself with sickness and gives poetic significance to terminal illnesses (Broyard, 1993). For dementia patients though, the situation is different. There are dementia patients who see the disease as a "Dark Lord", thus expressing their almost complete surrender to the illness, a situation in which there is only one winner – dementia (Broyard, 1993).

Stigma can be divided into two types: interpersonal stigma and self-stigma. The interpersonal stigma, the "public stigma" has three main components: a set of stereotypes, prejudice, and discrimination. Stereotypes are based on knowledge that is accessible to the public regarding other social groups. Stereotypes very quickly create a negative impression in society and negative expectations about people who belong to a particular group. Prejudice is created when people agree with the negative stereotypes that are popular in the group they belong to. Formed attitudes lead to discrimination against a group of patients due to behaviors that are perceived as negative. Thus, this negative perception gives rise to fear and a distancing of anyone who is identified with an unwanted trait/illness/condition. When people support a system of stigmatized beliefs, they exhibit a high level of avoidance and refuse to interact with the individuals marked as not belonging or ostracized (Sewilam, et al., 2015; Zimmerman, et al., 2016).

Self-stigma comprises the same elements as interpersonal stigma, creating a system of stereotypes, prejudice and discrimination. For example, patients with an "embarrassing" illness rely on knowledge about the disease in their environment. Based on the created system of stereotypes, they demonstrate a negative emotional reaction to their diagnosis and develop shame and low self-esteem due to their illness. An example of this can be seen in mentally ill patients (Sewilam, et al., 2015). Dobbs et al. (2013) argue that in addition to low self-esteem and a sense of shame regarding their illness, elderly people experience depression and a dwindling of social ties. The loneliness they experience damages their health and shortens their lives. Zimmerman et al. (2016) give another example of a group of people who experience self-stigma in their study, a group of dementia patients. According to the researchers, seniors with a diagnosis of dementia begin to feel "flawed" and are consequently rejected from their social circles. Their attitude towards the disease stems from cultural values according to which a person who needs mental health care and suffers from cognitive decline causes social discomfort, rejection and isolation. Dementia patients describe their brain as an old machine that has stopped working. They see their illness as a "black hole" that will eventually swallow them. When socially isolated by their family, they feel like a discarded "sock full of holes", which can no longer be used (Zimmermann, 2017, p. 77). Dementia patients not only feel rejected and "flawed", but the progression of the disease brings them to a state of dehumanization. Most of the patients describe seeing themselves in the future in the shadow of the disease as a tree that has shed its leaves, that is, the memories dearest to them abandon them, leaving them to feel like they will become an inanimate object (Zimmermann, 2017).

Susan Sontag wrote in her work that stigma causes different diseases to assume meaning and content. Thus, in her opinion, the illness determines the patient’s identity. For example, an illness that receives the meaning of shame is identified in the public with the patient’s inappropriate behavior. For example, AIDS is a disease of unacceptable sexual behavior that is interpreted by the public as deviant. Heart disease is also identified with an inappropriate lifestyle and is the cost of unbalanced eating.

Heart disease also symbolizes a result of the person’s weakness when facing the temptations in his life (Sontag, 1989). Then it is possible to conclude that dementia is associated with the weakness of the brain deriving from its lack of exercise (avoidance of reading books). Susan Sontag continued her argument, adding that the most frightening diseases are generally those identified with death. The general public is more afraid of the transformation of the healthy body, regular and known, into something without form, revolting, and not similar to a body at all, and reinforces these fears with prejudices regarding the source of the illness and distances themselves from the patient and the patient’s family and friends. Thus, with relative ease, stigma regarding different diseases is strengthened in the public through the fear of becoming sick with the same illness and the common fear of the illness in the public reinforces the existing stigma. Thus, a cycle is created that promotes the power of the stigma and creates additional fears, while creating a distance between the general public and patients with the disease (Sontag, 1989).

This labeling draws its power from the individual's prejudice which is based on incorrect information or even the complete absence of information regarding their apparent difference (Goffman, 1986). According to scholars from the Middle East, it is important to emphasize that the source of prejudice is socio-cultural beliefs prevailing in society which are directly influenced by religion. These scholars describe how Islam generates a common identity for about 90% of the population regarding a wide range of beliefs and attitudes in everyday life. Christianity and Judaism, at their core, are very much like Islam in this sense and are based on a set of similar values and norms. Thus, there are similar social phenomena that receive the same set of symbols, for example, certain illnesses (mental illness, cognitive decline, etc.). On the other hand, cultural beliefs are prevalent in the Middle East, according to which certain diseases are a punishment from God, the effect of the "evil eye" or evil transmitted from inanimate objects to people. Despite the advancement of medical knowledge, today, just as in the past, certain groups of patients are separated from the rest, although there is no danger of transmitting infection from one to the other. These are patients with mental illness and cognitive decline (Sewilam, et al., 2015, p. 2). Gove et al. (2016) can predict and foresee the level of stigma and discrimination directed at patients with a particular disease according to how nature and the source of the disease are presented in a specific culture, leading to a reality in which dementia is described in many different ways. Some cultures do not even consider dementia a disease, but a condition of "second childhood", and there are those who see it as punishment from god, the evil eye, or even the curse of old age. Modern Western culture views dementia as a mental illness. Unlike other diseases, mental illness and cognitive decline are still seen by the public as weakness and a source of shame and guilt. Patients with mental illness, as well as elderly people with dementia, worry about the way society will perceive them when their illness is revealed and their condition is known (Sewilam, et al., 2015; Werner & Shpigelman, 2019), which is not at all surprising. Many professional caregivers, despite their rich knowledge in the medical field, preserve the disparity between the different groups of patients and even initiate negative discrimination against them. Evidence of this appears in many medical records. The language used in medical correspondence reflects the deep-seated beliefs in the culture where these interactions take place and attests to a stereotype that maintains a stigma toward patients. These records are filled with expressions of stigma and discriminatory treatment (Goddu, et al., 2018; Werner & Shpigelman, 2019). According to additional research, professional caregivers for dementia patients are unaware of many aspects of the healthcare system they work in, which preserves the stigma against elderly patients. According to these scholars, as normative employees who are loyal to the institution, they maintain values that create stereotypes against the senior patients who are in their care. Thus, despite extensive knowledge in the field, healthcare workers maintain stigma and create discrimination (Zimmerman, et al., 2016). Furthermore, fear and anxiety rooted in society regarding dementia and its symptoms create public antipathy towards elderly patients and preserve the distance from the elderly. This antipathy is mutual and affects the elderly, who feel a sense of shame when recognizing the symptoms of dementia, and consequently close down and move away from a fearful and repulsed society that treats dementia as if it were a contagious disease (Rosato, et al., 2019). According to Werner et al. (2017), stigma tied to dementia patients can be more fully understood, when considering younger people (such as students), during a time in which the acquisition of a stereotype system that characterizes society and the construction of attitudes towards various social phenomena is created (Werner, et al., 2017). In order to understand the creation of social stigma, one must first understand the general values on which society is founded. Some scholars believe that a society that is prone to collectivism will inevitably have more stigmas towards different groups within it. For example, in a study that compared the level of stigma towards dementia and other mentally ill patients among students in Israel and Greece, the findings suggested a lower level of stigma towards dementia patients within Israeli society as opposed to Greek society. The explanation for this stems from the fact that Greece is defined as a collectivist society and Israel as an individualistic society. Thus, Greece and Israel have different general values, and despite similar negative feelings toward elderly people with dementia they develop different levels of stigma. Researchers believe that globalization and modernization processes currently taking place in Greece will turn it into a more individualistic society in the future and therefore more similar to the population in Israel in terms of stigma (Werner, et al., 2019).

Social stigma derives from superstition, which is often based on misguided stereotypes regarding various groups in society; even modern Western society is no exception. The origin of stigma as a social phenomenon begins with the labeling of an individual by another person as a result of a noticeable difference. This labeling allows for a clear distinction between two groups, "us" and "them" and the exclusion of those who are different. Perceiving differences as negative engenders negative feelings towards other people and creates social distance. There are many examples throughout history of how stigma creates social distance between groups in society. Over time, this distancing grows into negative social discrimination with dangerous implications for generations (Scazufca, et al., 2016; Heidarnia & Heidarnia, 2016). Although discrimination is one of the dangerous products of stigma, its additional consequences are equally damaging to society. Alongside labeling, prejudice, social division, and harm to social status, it also leads to the creation of individual-level stigma. For example, stigmatization of patients with mental illness consequently leads to a burden of shame and low self-esteem. Thus, social stigma towards patients with mental illnesses indirectly impairs their quality of life, prevents proper quality health care, impedes their ability to find work, and prevents personal and marital relationships. That is to say, stigma is a barrier to the social rehabilitation of these patients (Sewilam, et al., 2015). This situation becomes even more difficult when it comes to seniors. Fear of being identified with various health conditions, such as cognitive decline causes patients and their families to hide their illness, even at the expense of receiving better care and rehabilitation, and the elderly and their families feel socially distant due to the illness leading to withdrawal and the creation of conscious social loneliness (Sewilam, et al., 2015; Dobbs, et al., 2008). American researchers have found that about 85% of the general population believes it is difficult to talk to elderly people with dementia, and about 65% say these seniors are strange. In addition to this, the lack of available information and knowledge about the signs and symptoms of dementia, along with a negative stigma about dementia causes their families to see the condition as a normal aging disorder and prefer to hide it from others. For this reason, when dementia in the elderly is suspected and there is a need for referral to mental health services, due to fear of a negative social label, families will refuse to report or/and seek help from the authorities (Woo, 2017). In a study conducted in Israel among caregivers, professional caregivers who addressed pain and disappointment highlighted the discriminatory behavior and emotional distress of relatives towards dementia patients following the diagnosis of dementia. When asked about the expressions of relatives of elderly people diagnosed with dementia, professional caregivers who participated in the study reported seeing fear, shame, frustration, and despair on their faces. This finding is not surprising. Israeli society creates a sense of fear, shame, reluctance, and rejection towards mental illness. Thus, dementia, which is associated with this category, is subject to the same stereotype system that applies to mental illness. As a result, dementia patients are socially isolated and physically hidden from their surroundings. It is important to note that not only do caregivers feel shame and exhibit disengagement regarding treatment, but professional caregivers, as well, feel unable to create a system of equal and quality care for dementia patients. That being said, these days, awareness of the quality of care for these patients in Israel is rising, though the system still does not meet the needs of elderly patients with dementia. Furthermore, like family members, professional caregivers express difficulty and frustration due to a severe lack of resources and lack of personal experience to help this unique patient population.

Thus, in the case of caregivers as well as professional caregivers, the inability and unwillingness to provide appropriate treatment to dementia patients is a reflection of stigma rooted in Israeli society (Werner & Shpigelman, 2019). As a result of this reality, the general public preserves its prejudices and empowers them. The stereotypes rooted in society affect all of the groups that make it up, including various caregivers working in the health care system. For example, healthcare workers, despite all their medical knowledge and interactions with patients, have been found to have more negative opinions than the general public toward patients with cognitive decline (Werner & Doron, 2017).

Thus, it is not at all surprising that the highest levels of discrimination can be found within the healthcare system. Furthermore, according to findings from a study conducted in Israel, high levels of stigma towards the elderly are necessarily accompanied by high levels of stigma towards elderly people with dementia. And when stigma levels are lower for dementia patients, age-related discrimination is lower as well (Werner, et al., 2017). A study conducted in Brazil found that the risk of a negative attitude from caregivers spans between 9% and 15% when it comes to elderly patients. The most common expression of stigma in this study was the perception of elderly patients as dangerous. Approximately 56% of healthcare practitioners labeled people suffering from mental illness as dangerous, even if objectively the elderly people are not dangerous to their environment (Scazufca, et al., 2016).

Healthcare workers know that mental illness is not in itself identified with violence, however, as a result of a misguided social approach linking mental illness to violence and crime, the discrimination against mentally ill elderly people reaches 41%. This figure is significantly higher than the general figure in society (Scazufca, et al., 2016). More than 52% of respondents said they experienced discrimination as a result of their request for mental health care services and 42% of all patients responding to the questionnaire said they were treated differently (experienced poorer treatment) immediately after revealing a mental illness diagnosis (Sewilam, et al., 2015). Benjamin Woo comes to a similar conclusion in his research. Negative attitudes towards dementia are not limited to those who know nothing about the disease. True anxiety surrounding dementia is firmly rooted in the perceptions amongst caregivers of elderly patients with dementia. This fear expands and affects society. Approximately 96% of respondents felt uncomfortable disclosing information about an elderly patient with dementia in their family because they were convinced that cultural stigma regarding dementia in their family would cause the people around them to reject, dislike, and discriminate against them (Woo, 2017). In their work, Goddu et al. (2018) show that caregivers within medical organizations not only create discriminatory language but influence each other with it. As a result, stereotypical values accompany medical care from beginning to end and patients receive disrespectful and low-quality care. Thus, in medical visitation charts, physicians' attitudes towards patients can be identified. According to the authors, the language of stigma is characterized by discriminatory attitudes and influences medical decision-making in both regular and emergency care. When physicians receive written information in a language devoid of stereotypical attitudes, they provide higher quality, more tolerant and more sensitive treatment (Goddu, et al., 2018). This situation is similar in many European countries (Bai, 2014).

Many studies show that stigma towards the elderly suffering from mental illnesses associated with cognitive decline is rooted in modern Western society in general and its healthcare system in particular (Scazufca, et al., 2016; Sewilam, et al., 2015).

Epidemics, the public’s impatience with the patient, public fear of the spread of diseases in it, and common ignorance cause the public to isolate the patients from the general population. The isolation of illness generally is not associated with the true spread of the illness and is not influenced by its source. It is enough that the disease has frightening consequences or implies its ability to appear in the general public. However, as the general public gets to know more about the disease and the health system finds the treatment and knows how to treat the patients, the disease loses the myth that surrounds it (Sontag, 1989).

Woo, a Chinese-born researcher of American society, presents similar data. According to him, fear of dementia and cognitive decline associated with the disease create a negative stereotype towards patients with dementia. This fear is added to aging anxiety, which is becoming universal with global aging. Thus, the fear of cognitive decline together with aging anxiety gives rise to one of the most powerful stigmas.

Furthermore, there are certain cultures, such as the Chinese culture, where aging is seen as a decline in status and "loss of face" in the public eye (Woo, 2017, p. 122).

Other scholars also support Woo's claim. Old age, as well as various illnesses, has been subject to many stereotypes in modern Western society. Both conditions, old age, and disease, especially with cognitive decline, are associated with poor quality of life, physical limitations, and disability, increased need for medical services, and high costs of public medicine. Thus, social stigma is attached to old age (ageism) and grows when an older person also has a disease that involves cognitive decline or mental illness. For example, an elderly person with depression which, like all mental illnesses, receives negative social stigma is seen by society as a negative and socially rejected creature that is a burden on it. Society in this case focuses on the physical limitations of elderly people, their loneliness, poverty, and mental, physical and financial incapacity. Additionally, there is no doubt that by structuring values and norms towards social phenomena, culture creates certain stigmas. Thus, stigma toward aging and the elderly acts an integral part of modern Western culture (Scazufca, et al., 2016; Zimmerman, et al., 2016; Dobbs, et al., 2008). In order to understand why modern Western society is scared of dementia, Martina Zimmermann (2017) tries to explain the disease. Caregivers and patients alike describe the disease as social self-loss, disappearance and no longer belonging to society. The sense of shame that accompanies the process of loss of function creates a reality of embarrassing illness, especially when the connection between mental illness and dementia is emphasized (Zimmermann, 2017). Modern Western society addresses mental or physical disabilities among young people differently than in the elderly. Elderly people are viewed as delicate, fragile and in need of protection from society. As opposed to this, young people with similar disabilities are given better and completely different social opportunities. As a result of a variety of societal attitudes about the age of people with disabilities, young people with disabilities receive wide-ranging social support, such as rehabilitation, independent living and financial support. Seniors, on the other hand, can expect a different future - to spend the rest of their lives and their last days in institutions with no right to choose another destiny for themselves. These institutions are responsible for the deprivation of identity of their elderly residents and for creating and maintaining a stigma regarding them in society (Dobbs, et al., 2008). Furthermore, in his classic work on total institutions, Goffman addressed the tendency of institutions that treat people with cognitive decline to concentrate all of its occupants' concerns and needs under a single authority, while employees are constantly supervising the institution's patients. This system has one purpose, to meet formal goals set by society. Thus, the rigid rules, feature-based or disease-based separation, and strict schedules not only prevent privacy and respect for patients but eliminate almost completely their sense of identity (Goffman, 1961). Like Goffman's institutions, nursing homes take a patronizing approach to elderly people with dementia. When the institution detects further cognitive decline in the elderly patient's condition, it immediately takes steps to move them to the next level of care, with no consent on their part. At this level of care, the elderly patients' basic rights are naturally denied (Dobbs, et al., 2008).

In his classic work on social stigma, Goffman claimed that stigma management is a general feature of society, a process that takes place wherever there are norms of identity. These are the same traits, whether they are significant differences, differences traditionally defined as stigmatizing, or insignificant differences, which the person is ashamed of or ashamed to be ashamed of. Thus, one can assume that the normal role and the role of the stigma holder are parts of the same whole (Goffman 1986, p. 130). An example of this may be elderly people who find that they are no longer able to remember the names of their close friends and so may avoid participating in social gatherings if there is a chance that they may run into friends. In this way, they emphasize their embarrassment, one that leads to human traits that do not go hand in hand with healthy old age. This is how Goffman defined the normal deviant. Individuals measure the existing stereotypes regarding themselves and begin to fear the social stigma that may keep them away from society (Goffman, 1986). Such behavior in elderly people is not at all surprising. A social system, as a well-oiled machine powered by values and norms, determines the individual's behavior and dictates and preserves society's preferred choices (Heidarnia & Heidarnia, 2016). Researchers from Israel present similar findings. Israel as a multicultural society exhibits strong ties between cultural values and the construction of stereotypes. An individual's emotional and behavioral response is determined through a stereotype system. A study conducted in Israel showed differences between the Jewish majority and the Arab minority regarding levels of stigma toward dementia patients. The Jewish majority was characterized by lower levels of stigma than those of the minority. The explanation for these differences stems from the fact that Arab society in Israel is characterized by a tradition of respect for the elderly and family values such as respect for the elderly due to their advanced age. Thus, Israeli Arabs focused more on the mental illness of the elderly than on their age. That being said, cultural values, even among traditional societies, are flexible and change as a result of different social influences. According to the study's findings, the changes taking place in Arab society in Israel are evident in the field of cultural values and norms. The exposure of the Arab minority to the process of modernization and openness to the attitudes of modern Western society is replacing traditional values with individualism and liberalism. Thus, the stigma level for elderly patients with dementia will decline in the future and be more similar to the stigma of the Jewish majority (Werner, et al., 2017).

When mapping the consequences of stigma and discrimination against dementia patients, it is important to emphasize the positive consequences as well. Some researchers claim that creating a stigma against elderly patients with dementia allows these patients to be protected from violation of their rights and property, expediting the process of gaining these rights and additional social security payments. Nevertheless, it is important to note that most of the consequences of stigma and discrimination are negative and devastating for society and the elderly alike (Werner & Doron, 2017).

Social stigma towards dementia patients causes society to take charge of the elderly and completely disregard their wishes. It isolates them through a severe stereotype system while building a clear-cut boundary between these patients and the rest of society. While stigma is a natural product of society's cultural values and norms, these social institutions are gatekeepers who create appropriate social conditions. Some scholars claim that the legal and political systems are major social institutions that increase the stigma toward dementia patients from a micro level to a macro level. That is to say, labeling, creating a stereotype system, and stigma that results in social discrimination against certain groups is impossible without creating conditions through social institutions such as the legal system and the political system. Researchers from

Israel who have examined stereotypes and stigma toward dementia patients in the judicial system have argued that there is a negative label attached to dementia patients and their families. The legal system not only clings to the leading stereotypes but preserves them with its decisions in the field. This is much like the political system, which fosters social stereotypes, stigmas and discrimination while creating laws that preserve the social order and its practices. An absolute lack of knowledge and understanding on the issue of elderly patients with dementia causes decision-makers and high-level policymakers to stick to a medical diagnosis of dementia while ignoring the social implications and not understanding what stage of illness the elderly person is experiencing. Courts rely primarily on medical diagnoses to decide on issues of cognitive and physical inability. This general attitude toward dementia patients and their families not only reinforces the stigma but gives legal validity to the label (Werner & Doron, 2017).

In recent years, dementia has become a filter of fear. This fear is rooted in society while creating stereotypes towards dementia patients and reinforcing stigma against them (Zimmermann, 2017). Thus, there is a need for eradication and reduction of stigma towards patients with dementia. The most effective tool in the fight against the phenomenon of stigma in society in general and public medicine in particular is most likely education for tolerance, understanding, and acceptance of others as they are (Scazufca, et al., 2016; Woo, 2017). Middle Eastern researchers also agree with this claim. In their opinion, it is worthwhile to begin educating family members who are close to the patients and cultivating acceptance of sick relatives. It is important to eliminate the guilt and replace it with the ability to emotionally support the patients. It is also important to root out negative attitudes and raise awareness of the fact that no disease causes shame to those who have it, but only old stereotyping systems that prevent treatment and rehabilitation. Individual and family-level education should be conducted in tandem with building values in the education system for the young generation at schools, colleges and universities (Sewilam, et al., 2015). Woo argues that in the case of dementia patients, it is useful to start providing up-to-date and correct information to the family of elderly patients with dementia. Providing information creates an atmosphere of acceptance and lowers the public's anxieties regarding dementia. Lowering the level of fear will prevent or at least reduce the stigma in society with regard to elderly people with cognitive decline (Woo, 2017; Werner & Doron, 2017). Michael Rosato et al. (2019) extend this claim. In their opinion, providing accurate and correct information about dementia is extremely important for older age groups with less of an educational background, as the levels of anxiety surrounding disease among these groups are among the highest in society (Rosato, et al., 2019).

Goddu et al., (2018) argue that as part of education for tolerance, tools for written language awareness should be developed, especially in the health care system. When a writer uses neutral language to describe someone, this reduces the formation of negative attitudes by eliminating stereotypes. In addition to this, it is important to initiate medical studies of the development of neutral written language that remains professional and objective. It is important to instill neutral language among veteran caregivers as well, so that they can be aware of their coworkers' negative bias, stigmatizing and even discriminating against certain patients. Healthcare workers who are aware of the fact that written language provides better and more effective quality of care are agents of social change that can reduce social discrimination by eliminating stigma (Goddu, et al., 2018). For example, the Japanese government has embarked on a project aimed at replacing words used in professional language regarding dementia patients. The instruction for the description of dementia patients is "cognitive symptoms" (ninchishyo), rather than "dementia" (chi ho), which was previously used. The Canadian government has begun a similar initiative and previous practices will be replaced by new alternative concepts in an attempt to counteract the existing stigma towards dementia patients (Dobbs, et al., 2008). Even in Israel, it is believed that education that embodies values protecting dementia patients should begin among healthcare professionals at all relevant levels. Scholars argue that every medical institution should develop projects that encourage empathetic treatment and support for patients with dementia (Bentur & Sternberg, 2019). Also, researchers from Israel presented similar findings. Young age, higher education, and close acquaintance with dementia patients are characterized by more positive attitudes towards these patients. These subjects also exhibited low anxiety levels regarding dementia patients and high levels of knowledge regarding this disease (Werner, et al., 2017). Other researchers believe that education, a culture of patience, and an awareness of stigma-generating language are of great importance. In this context, it is important to start with the close environment of groups that are subject to social stereotypes. In the case of dementia patients residing in an institution, they recommend reducing separation due to dementia. Seniors could, for example, sit in a dining room and participate in daily activities at will and without division into groups based on a dementia diagnosis. Additionally, to reduce the system of stereotypes among elderly residents and employees of an institution, a group of dementia patients should not be separated from other residents, at least when it comes to the initial stages of illness. Thus, a positive value system will be built naturally and stigma will be reduced (Zimmerman, et al., 2016).

3.5.Totalitarian care: tackling the phenomena.

Eldercare, especially in elderly patients with dementia, is a complex process that raises many questions for the patients themselves as well as for their caretakers. The nature of the interaction between the caregivers and the elderly patients is determined not only by the variety of the elderly patients’ needs (medical, physical, social, psychological, etc.), but also by caregiver-related factors (such as: knowledge about old age, skill and abilities, attitudes in regards to old age, care for the elderly and personality traits) (Sanchez-Izquierdo, et al., 2019). The caregiver-patient relationship moves on the continuum between two completely opposite approaches, one is paternalism (focusing on the caregiver), and the other, is personal autonomy (focusing on the patient). Paternalistic treatment is based on the idea of the superiority of the caregiver in the context of care. According to this approach, the caregiver is not only a higher authority but also knows what the patient needs better than they do. Usually, the caregiver believes that he or she is acting with good intentions or for the good of the patient. This paternalistic approach is traditional in medicine. Today, the health care system in a modern Western society, a society that advocates social equality in general and equality in health care in particular, includes patients in making health and care decisions. This not only provides a new definition of the patient in the system but is aimed at changing the patients’ overall perception and transforming them into healthcare system customers who need health and medical products, while maintaining personal autonomy throughout the treatment (Fernandez-Ballesteros, et al., 2019).

Even though the quality of communication in the healthcare arena is determined by a variety of factors and traits that characterize caregiver and patient, healthcare for patients with dementia still remains paternalistic, as has historically been the case. Today, paternalistic attitudes and behaviors among caregivers are seen as an objective standard of modern medicine – this includes the violation of the autonomy and freedom of elderly patients that occurs while increasing the dependency of these patients on their environment (Sanchez-Izquierdo, et al., 2019). To understand the concept of "paternalism", it must first be defined. According to the etymology of the term, paternalism is based on the Latin word "father" (pater). Historically, in patriarchal cultures, the father is a supreme authority, responsible for welfare, economics and decisions in areas to do with family. The concept of "paternalism" first appeared in the 19th century as part of a critique of the violation of individual freedom and autonomy. According to paternalism advocates at the time, the violation of the individual's freedom and autonomy is inevitable and even necessary, as it arises out of concern for others and their well-being, especially when it comes to matters of health. Some have argued that paternalism is defined by motive. For example, generosity, whereby a decision-maker acts for the good of another who is unable to make decisions at all. As Gerald Dworkin (1972), who was among the first to define medical paternalism, describes it:

> “The interference in a person’s liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the persons being coerced." (Dworkin, 1972)

Paternalism in general and medical paternalism in particular is characterized by the fact that the physician/caregiver is responsible for the treatment and takes complete control over the course of treatment and its consequences when what guides this is in the best interest of the patient (Carrard, et al., 2017). The health system, traditionally, has been characterized by a highly hierarchical structure that organizes the distribution of power among various stakeholders. This hierarchical organization can be traced back to the early days of medicine, where authority was often concentrated in the hands of a few - typically physicians and medical institutions. This structure has evolved over time but still retains many of its original features. In ancient civilizations, healers and physicians held significant power, often based on their knowledge of herbs and healing practices. This knowledge was not widely accessible, creating a natural hierarchy. As medical knowledge advanced, institutions such as hospitals and universities emerged, further entrenching hierarchical structures. Physicians, often seen as the gatekeepers of medical knowledge, held authority over patients and other healthcare workers. The establishment of medical licensing and professional organizations solidified the power of physicians. This created a clear hierarchy where doctors were at the top, followed by nurses, allied health professionals, and administrative staff. In contemporary health systems, the distribution of power remains hierarchical. Physicians typically have the most authority in clinical decision-making, while nurses and other healthcare providers play supportive roles. However, the dynamics can vary based on the healthcare setting and the specific roles of various professionals. Health systems often have complex administrative structures, with executives and managers making strategic decisions that affect the entire organization. This can create a disconnect between administrative decisions and frontline clinical practice. Still, even in modern medicine, paternalistic care forms the basis of the health care system.

At the macro level, health policy is often shaped by government bodies and large organizations, which can create additional layers of hierarchy. Decisions made at these levels can significantly impact local healthcare delivery. Although there is some flexibility in medical care in modern Western society, the most dominant approach to care for the elderly in general and especially in long-term care institutions is paternalism. Upon reaching old age (or/and an institution) the elderly patients become more passive, and the caregivers take a more active role until they eventually take everything related to the care upon themselves. Here too, the caregivers wish to make decisions for the benefit of the patients. That being said, as the patient's physical dependency on the caregiver increases, the caregiver allows less and less room for the patient's input when it comes to decisions in different areas of life. That is to say, to create a better and more comfortable life for elderly patients, hierarchical relationships that lead to underestimation of the elderly are created, and later can even lead to a complete disregard of their will and humanity (Sanchez-Izquierdo, et al., 2019; Carrard, et al., 2017). Furthermore, the physical limitations, such as disability or even the slowness of the elderly patients, are often interpreted by caregivers as a sign of frailty and perceived as a general disability on the part of the elderly patients in a variety of areas of life. Thus, even if an elderly person does not suffer from mental and/or cognitive decline, he or she is perceived by the caregiver as having functional, cognitive and mental disability. This misconception creates an attitude that leads to treating elderly people as if they were children. This attitude leads to a hierarchy in which the patients are completely dependent on the caregivers and have no right to express themselves at all. Caregiver paternalism which is initially aimed at providing the patient with support and confidence later becomes utterly paternalistic, with the input of the elderly patients being completely disregarded, even if they can give it (Sanchez-Izquierdo, et al., 2019). This paternalistic approach to eldercare, regardless of the patient’s mental capacity, is the result of the pressure exerted by powerful social groups that are opposed to accepting elderly people in society according to their abilities (Fernandez-Ballesteros, et al., 2019). Moreover, many factors affect elderly dementia patients’ personalities, such as their physical health, functional activity, social psychology, life history, etc. Dementia, as a disease, is one component of the general complexity that characterizes an elderly patient's personality. When determining a respectful and humane treatment approach this is not the most important factor (Roen, et al., 2018). Sickness does not constitute the only basis for treatment. Just as with healthy elderly people, in cases of dementia, elderly patients can express themselves and make decisions in daily life, increasing their self-esteem, as well as their contribution to society. Even in the case of a chronic illness or disability, the individual's humanity should be respected (Smebye, et al., 2016). Thus, despite the frailty that characterizes elderly patients and the complexity of their illness, care for them requires their involvement in the treatment. They no longer want to comply with instructions but rather demand that they be full partners in health care, regardless of their functional capacity. The complexity of this matter further emphasizes the value of autonomy in health care as the continuation of autonomy in modern society. The Greek “autonomy” means "self-rule" or "self-governance" (auto = self; nomos = rule or governance). That is to say, an individual's self-determination will include self-management, responsibility for his or her actions as well as drafting and executing life plans (Fernandez-Ballesteros, et al., 2019, p. 2).

The idea of autonomy in medical care is not new. This person-centered care idea begins with Carl Roger’s (1959), theory of human development. According to this theory, the functioning of an elderly person is not a result of age and/or illness, but a result of the interplay between characteristics of the individual and his or her psychosocial environment (Rogers, 1959). These findings have been validated in scientific studies. Patient-centered medical care is respectful care, taking into account the patient's personality, values, needs and culture (Carrard, et al., 2017). Similarly, the concept of the patient at the center of care is also important for the quality of health care for the elderly, especially when there is dementia in the background (Fernandez-Ballesteros, et al., 2019; Roen, et al., 2018).

Furthermore, Erikson’s theory, an individual develops throughout his entire life until the day of his death. In other words, all the changes that happen in the elderly person’s life constitute achievements that are milestones throughout his development, even when talking about dealing with illness. Thus, the drawing of conclusions based on different events that occur in life, even when this is a chronic illness, contributes to his development as a person. When the individual does not succeed in producing benefits from the conclusions that arise from the events that occur in his life, he feels a lack of meaning and disappointment (Erikson & Joan, 1997).

When raising issues for discussion related to the autonomy of medical treatment, truth-telling must be considered as one of the most important components of autonomous care. For example, in a study conducted in Croatia, it was found that not every patient who can make decisions for him or herself would prefer to know the whole truth regarding medical treatment. It is apparent from this study that in post-communist countries areas such as medicine still employ a paternalistic approach where "the doctor knows best" and decides which information is to be provided to the patient (Murgis, et al., 2015).

According to Illouz (2007), modern society is characterized by the multiplicity of information in a variety of fields. With time, the multiplicity of information has become a real burden that harms the individual’s ability to quickly make decisions that by nature are based on limited information. The risk of the matter is that an overload of information based on poor knowledge harms the individual’s ability to make useful choices without being harmed (Illouz, 2007).

Lila Skountridaki (2019) disagrees with the idea that caregivers should decide on the information provided to the patient. She argues that progress toward a more equal communication style in modern medicine is preferable to other styles, since through it a higher level of care can be achieved. In her opinion, every relationship asymmetry is to the detriment of both the patients and caregivers. Thus, extreme paternalism, as well as total autonomy, are not preferable when it comes to care. That is to say, the consumerism and commercialization that characterize the autonomy of modern Western society push the patient (consumer) to consume/choose medical services (treatments) that are inappropriate or even harmful to their health. On the other hand, treatment based on paternalism prevents patients from participating in decision-making and choosing caregivers and doctors. Thus, the quality of care is harmed by both an extreme paternalistic approach and complete autonomy (Skountridaki, 2019). Researchers from Switzerland also see an advantage in more equal treatment approaches. They believe that treatment that positions a patient at the center and takes into account his or her wishes brings greater benefit to both patient and caregiver. Furthermore, patients who feel that they are at the center of care not only report greater satisfaction with the caregiver's work but also demonstrate a higher response to recommendations following medical counseling. An approach that views the patient as an equal not only improves the treatment, but reduces rates of patients' legal claims with regards to medical malpractice (Carrard, et al., 2017). The basis of this assumption lies in Roger's approach. In his opinion, the primary function of a caregiver is to respond to a patient with empathy and interest and to let the patient lead and establish treatment principles. In this way, a patient will experience unconditional positive appreciation, a feeling of self-worth, and a higher willingness to cooperate with the caregiver (Rogers, 1959). Like Rogers, many scholars demonstrate the crucial importance of maintaining relationships that empower the autonomy of elderly patients. These are respectful relationships, allowing for independence in decision-making. At the same time, in reality, among caregivers, maintaining the autonomy of elderly patients is still associated with physical and economic insecurity, leading to an increase in the falling rate of the elderly and poorer health. For seniors who live in institutions, the disrespectful attitudes of staff and having no option of taking control generate stereotypes, give rise to stigma, and cause overprotection. The elderly residents want to be treated "as adults and not as children", "with respect and esteem". These seniors want to make decisions and choices, to be full partners in care. They want to be "informed and asked". Instead, the caregivers provide unnecessary help, prevent certain activities, socially isolate the elderly, and build a "suffocating" environment (Sanchez-Izquierdo, et al., 2019, p. 1516). Other researchers also claim that treating seniors as children is not only wrong and harmful to patient dignity, but undermines the humanity of senior citizens in general and dementia patients in particular.

The elderly are not "empty shelves", nor newborn children. They possess a magnificent personal narrative and the preserving of the unique identity of each one is morally important to the existence of society. Thus, comparing pediatric patients with dementia patients or dementia to a second childhood highlights the ignorance and lack of knowledge about this disease among caregivers themselves. Also, this misleading approach results in a permanent downward appreciation of the humanity of dementia patients and harms the quality of care (Jongsma & Schweda, 2018).

According to Rogers, patients naturally progress toward experiences that they translate as positive and this drives them to overcome difficulties/illnesses. The caregiver must help the patients acquire effective skills to help them fulfill their abilities in dealing with obstacles. Rogers adds that patients do not strive for balance and relaxation, but for strengthening their resolve in the journey through health obstacles. Thus, the role of a caregiver is not to seek balance in treatment and not to take a leading role, but to follow the patient's wishes in treatment. Patients do not need solutions from caregivers because they know what the best solutions to their problems are. The patients need an empathic and thoughtful way to achieve these solutions. Thus, because humans are fundamentally good, patients will always experience compassion and empathy on the part of the caregiver, regardless of their background, thoughts or behavior (Rogers, 1959).

There is no doubt that a good relationship between the caregiver and elderly people with dementia is essential for the proper care of this patient population. This relationship begins with the caregiver. That is to say, improper practices and negative attitudes toward elderly patients may not create a good environment for the increase of quality care. A caregiver who can provide an individual service to the elderly patient to the satisfaction of his or her workplace will provide better care. As opposed to this, a burnt-out caregiver with prejudice and stereotypes regarding old age and the elderly is unable to build a good physical and mental environment for the patients, especially when they are elderly. The physical conditions in which the treatment takes place are also of crucial importance for caregivers and patients. When a room is spacious and physically adapted to the needs of the caregiver and patient, the quality of care increases, and when physical conditions are uncomfortable with a lack of basic resources - the quality of care is harmed. In addition to this, studies show that when there are enough caregivers in relation to the amount of work, with an atmosphere of innovation, acceptance and respectful leadership - the treatment they give to dementia patients is of higher quality. Additionally, the orientation of the care team to patient-centered care was directly dependent on their education and skills in elderly care (Roen, et al., 2018). Furthermore, Brooker (2004) proposes a theoretical framework for the advancement of care in which an elderly dementia patient is at the center of care. Providing care not only increases the quality of care for seniors with dementia but also raises the levels of satisfaction for caregivers in their work with elderly patients. This model is named VIPS and has 4 components :V-valuing people with dementia and those who care for them, I – for treating people as individuals; P- for looking at the world from the perspective of the person with dementia; S – for a positive social environment in which the person living with dementia can experience relative well-being (Brooker, 2004).

A variety of daily activities (such as: feeding, dressing, bathing, armchair transferring and outings) based on this model allows the development of a positive attitude toward dementia patients among the staff. Implementing this model in the caregiver's routine work allows him or her to see the patient’s personality and make the communication more pleasant and humane (Roen, et al., 2018).

When discussing the autonomy of the individual in a modern Western society, there is a wide range of interpretations given to this concept, especially in areas of medicine and health. According to researchers from Switzerland, autonomy includes self-control, integrity, self-definition, free will, respect, individuality, independence, responsibility, self-recognition, etc. In addition to this, autonomy is defined as a supreme value in Western medicine and is one of the important principles guiding medical care in a modern society, comprising beneficence, non-maleficence, and justice (Murgis, et al., 2015). At the same time, when talking about a person physically and cognitively dependent on caregivers, as in cases of advanced dementia, the issue of autonomy becomes not only challenging but even impossible. There is no doubt that maintaining individual autonomy in care is important, but discussing caring for the elderly, especially patients with severe dementia in the common definition in Western culture seems irrelevant (Smebye, et al., 2016). Additionally, dementia patients cannot express or even produce new insights with regard to their critical condition. In advanced stages of dementia, elderly patients lose understanding of personal narrative and the perception of the meaning of a variety of life events. They lose the definition of the past, present and future life they experienced before the illness. Thus, the absence of a sense of continuity in life and a lack of meaning of existence raises the question of the need for autonomy for elderly patients with dementia (Smebye, et al., 2016). Furthermore, paternalism in treatment requires that the caregiver take maximum responsibility for the quality of care. In other words, a caregiver will provide the patient with maximum quality medical care, while responding to the patient's needs, as what is good for the patient is good for business. This is unlike autonomy, where a patient chooses the treatment and will often do so taking into account the cost of care rather than his or her health (Skountridaki, 2019, p. 1688). According to Angelo Mogan (2017), medicine and health are necessary areas for sustaining paternalism in modern society, especially when it comes to patients with a lack of cognitive ability. That is to say, a paternalistic approach allows for social protection against neglect, especially among patients who cannot seek government assistance (Mogan, 2017).

Researchers who oppose paternalism in health care believe that paternalism defines the patient as incapable of functioning as an independent person, as if the individual is pre-defined as having no physical and mental capacity. They argue that one of the most important problems of a paternalistic approach to medical care for the elderly is a "self-fulfilling prophecy". That is, an elderly person without cognitive decline gives over control of decision-making and choices to family members and/or formal caregivers, moves away from social life, and loses the meaning of life. In the same way, elderly patients with dementia, along with their diagnosis, relinquish control of their life as a result of pressure from their caregivers, as if they were at an advanced stage of the disease and no longer able to function (Fernandez-Ballesteros, et al., 2019, p. 2).

However, when there is a cognitive decline, a paternalistic approach is important in treatment, although the proportionality of paternalism in treatment is more important. That is to say, the caregiver works with the elderly patient with dementia while providing crucial necessities, in both decision-making and other functions. Researchers from Madrid disagree with the argument that patients with mental deterioration are patients without a past and future. In their opinion, an elderly person with dementia is not without continuity as long as caregivers respect him or her as a person with a past and values. That is to say, every person, even a dementia patient, who receives respect, as a person, continues to exist as part of human society (Fernandez-Ballesteros, et al., 2019). When caregivers do not see a patient as a person, their approach not only harms the quality of care, but the sanctity of life as a supreme value in any human society (Smebye, et al., 2016). At the same time, researchers from Croatia argue that autonomy is not the most important consideration and offer the example of a post-communist society, where a caregiver is still expected to take a paternalistic approach and make treatment decisions for a patient, who can make decisions but does not. Accordingly, how should a patient who is unable to make a medical decision understand the nature of the consequences of decisions made (Murgis, et al., 2015)?

Carrard et al. (2016) believe that treatment must be provided in a communication style that the patient prefers. In other words, some patients will determine the medical treatments they want to undergo and will require certain treatment outcomes. At the same time, other groups of patients exist, those who find it difficult to move to a more equal approach and strive for paternalistic treatment, as in post-communist countries. Such patients would expect a caregiver to take an active role in the treatment, choose the best treatment for them, and monitor its outcomes. Thus, elderly patients, people with less education, and severely ill patients will prefer paternalism as a communication style in treatment. In such a situation, an experienced caregiver must take into account that these are patients who do not want to take responsibility for the treatment and that their levels of fear and anxiety are high in advance . In addition to this, fear of the therapeutic encounter may prevent patients from making informed decisions (Carrard, et al., 2017). This is easy to see in medical emergencies, which require a quick professional response to save lives. Individual autonomy in emergency medical care is not a dominant approach in the decision-making process (Murgis, et al., 2015).

Like all patients, dementia patients are also able to express their preferences regarding their own lives. Their humanity depends not on the progress of their illness but on the direct treatment of their caregivers. Autonomy in caring for these patients is not impossible. Like paternalism, this is not the only possible method for the treatment of dementia patients. In other words, developing respectful communication and proper human care practices has been a complex and ongoing process for many years. Also, respecting the autonomy of elderly patients with dementia means that formal caregivers and their family members must help preserve the values and fulfillment of the interests of the elderly and when elderly patients are less able to function the caregivers must fill the void and continue to work for the elderly up until their death. Just as with any treatment, care for the elderly should also be in their best interest. Promoting proper care and prevention of harm is the moral duty of caregivers (Smebye, et al., 2016). In this context, it is important to view the elderly as products of society. As they reach old age, seniors believe that losing personal autonomy that has been an essential part of their lives is a natural course of aging and so they feel it is best not to oppose this course of action. Thus, when elderly patients object to caregiver decisions, they do not voice their objections and comply with what has been decided (Fernandez-Ballesteros, et al., 2019).

To achieve optimal care for the elderly in general and for patients with dementia in particular, the caregiver must begin to know the elderly patients and their personalities. This is the treatment that maximizes autonomy alongside organizing a physical environment tailored to the elderly patients, according to their needs and wishes. According to researchers from Madrid, such care leads to dignified and considerate treatment, creates social interaction between caregivers and patients, maintains the psychological health of the elderly, and lowers their cognitive decline. Benefits are also evident when it comes to caregivers – an equal attitude toward elderly patients creates satisfaction in their work and reinforces a sense of importance. On the other hand, caregivers who demonstrate extreme paternalistic behavior show lower satisfaction and contentment with their work as caregivers, and their sense of the quality of communication with patients is negative (Sanchez-Izquierdo, et al., 2019). For Skountridaki (2019), autonomy is not just the expression of individualism in modern Western society. It is the responsibility for life in general and responsibility for health in particular. Responsibility for health also includes future health planning and the use of current and future medical services. So, it is natural that some people won't take responsibility for a variety of reasons. In addition to this, the strengthening of individualism in modern society increases consumerism and the commercialization of health. Along with the choices that consumerism has brought with it, there are also negative consequences. The patient has become responsible for the decision-making process, thus making health decisions that could be detrimental to him or her. The situation becomes even worse when it comes to seniors, especially dementia patients (Skountridaki, 2019). Other scholars also support this claim and are sure that autonomy among elderly people can have negative consequences for them. In other words, seniors living in their homes while their functionality levels decline are at risk of problems with the consumption of food, falls, personal hygiene, managing drug treatment, and social isolation, especially when living alone. Thus, treating dementia patients raises many ethical and moral dilemmas. A delicate balance between maintaining their personal autonomy and providing safety and well-being, especially when living at home, whether with their family or alone, will result in more positive feelings. It is most likely that the solution for maintaining the maximum level of autonomy possible for patients with dementia is a moderate paternalistic approach. That is when the maximum possible autonomy is maintained alongside maximum safety in care (Smebye, et al., 2016). In Skountridaki's (2019) opinion, a paternalistic approach to treatment also allows patients to get everything they need to improve their health or maintain their existing condition, using smart medical services. The advantage of this is that a patient does not take personal responsibility for outcomes in treatment (Skountridaki, 2019). Admittedly, it is difficult to maintain paternalism in its moderate form when it comes to the care of the elderly. According to Smebue et al. (2016), this emerges in its extreme form, especially in old age institutions, which is not at all surprising. There is a conflict between maintaining the autonomy of an elderly person, especially a dementia patient, and the comfort of the caregiver in his or her work with patients with physical and mental impairment. In addition to this, the less skilled and experienced the caregiver in care for the elderly, the more they are prone to paternalistic treatment, while completely disregarding the preferences of the elderly patients. On the other hand, for patients with dementia, especially in the advanced stages of the disease, the need for a sense of security outweighs the need for autonomy or individualism in treatment. For dementia patients, a feeling of being "at home” begins with a sense of belonging and comfort wherever there is a caregiver who understands this and cares for their identity continuity while maintaining safety in care (Smebye, et al., 2016). But, when caregivers “know best", there is a risk that they will forget their primary role, providing quality care and preventing harm to others. In addition, a paternalistic approach gives the caregiver a sense of complete protection from legal inspection by the authorities, even when the caregiver's activities are far from the well-established medical standards (Mogan, 2017). Thus, exaggerated paternalistic treatment by caregivers not only eliminates individual autonomy but transfers treatment to a cold, emotionally neutralized arena that becomes completely formal and even inhumane. The communication in such treatment, when the caregiver “knows” everything better than the patients, becomes non-verbal on the part of patients and devoid of identity (Sanchez-Izquierdo, et al., 2019). Researchers from Germany also agree with this claim. In their opinion, paternalism enhances the "parental" approach of the caregiver and thus reduces the moral significance of the elderly patient’s past life. As a result, the caregiver's behavior towards the elderly patient becomes less and less respectful, mocking, and even humiliating. Seniors are not children. But even if they were to receive child care, they would probably receive care which is more sensitive and therefore necessarily more human (Jongsma & Schweda, 2018). According to Rogers’ human-centered approach, throughout the interaction caregivers should avoid their own interpretation of things completely, but reflect on what is being said for emphasis and clarifications that are important to the patient. All this should be considered while performing non-judgmental behavior, and not from a "doctor knows best" approach. A caregiver is a tool for achieving positive feelings in the patient during treatment (Rogers, 1959).

There is no doubt that paternalism can be beneficial for caregivers of dementia patients. Thus, moderate paternalistic communication is based on a constant assessment of risk-benefit in treating dementia patients, facilitating safety and lowering risk. But paternalism, too, inevitably decreases the level of autonomy for elderly patients, and may not be appropriate for healthy old age or the disease in its initial stages (Smebye, et al., 2016). Also, a paternalistic approach is needed to protect patients who cannot worry about their care due to their mental maturity or cognitive decline, as in elderly people with dementia (Mogan, 2017). Additionally, the common neglect in the health arena among the elderly has led to a great deal of responsibility being passed on to governments in modern societies. Thus, governments are responsible for providing better care, even for those who cannot claim it for themselves (Skountridaki, 2019). Additionally, the autonomy that requires the performance of medical action with informed consent requires the caregiver to present all risks associated with performing or avoiding medical action. When a patient makes his or her own decisions, proper medical treatment at the right time may not be provided. In other words, the absence of a medical action, or late-stage action, can harm the results of treatment and the achievement of optimal health. On the other hand, individuals have a right to refuse medical treatment, even if an injury to their health is expected. It is important to remember that although medical paternalism is traditionally a major part of medical care, the patient is allowed to consider all the implications and make a decision based on the information received, even when it comes to the elderly.

Admittedly, this is not the case when it comes to a patient with a lack of cognitive ability (Mogan, 2017). Researchers from Madrid support this claim. They believe that the strengths of Rogers' approach led to the possibility of building a quality relationship between caregiver and patient, as the experience of a lack of judgment is unique and listening is very important. However, for elderly patients with dementia, the lack of active steps in treatment and taking responsibility for the treatment at a time that is required, harms the treatment and does not achieve good medical outcomes, endangering the patient and risking death (Fernandez-Ballesteros, et al., 2019).

Some researchers recommend adjusting treatment according to their elderly patients. That is, taking into account not only the fragility of old age and the physical dependence of the elderly but also their cognitive abilities, allowing sufficient independence, along with assisting in a response to a request or need, while taking into account the wishes of the elderly. Also, any interaction regarding care and other needs must begin with interpersonal awareness, patience and consideration of existing limitations (Sanchez-Izquierdo, et al., 2019). Researchers from Switzerland also present findings in their work that support the work of a caregiver who adapts to his or her therapeutic environment and chooses from a variety of approaches the one most suitable for the situation and personality of the patient. In their opinion, this is not a universal, standardized solution that fits everyone and each treatment-seeking patient needs a different therapeutic style. It is the responsibility of a caregiver to adapt the communication style to successful medical care. Adapting the type of communication to the patient is an example of the professionalism of the caregiver. Also, the caregiver's respectful communication gives him or her a set of positive behaviors that are interpreted by the patient as good care, such as: non condescending conversation, a smile, active listening, politeness, etc. Additionally, respectful communication is important with every patient regardless of their illness or age and equal communication has other notable advantages. For example, patients develop fears and anxieties with more paternalistic caregivers and also see them as less tolerant and more aggressive. As opposed to this, when a caregiver speaks to patients as equals, listens, and nods, patients report low levels of fear and anxiety regarding medical care, trust caregivers, and see them as more tolerant (Carrard, et al., 2017). Regardless of the degree of autonomy or paternalism in care, quality medicine is based on respect and trust between the caregiver and the patient. Thus, respectful communication between caregivers and patients is likely to result in better collaboration and higher quality of care (Murgis, et al., 2015).

Basic human care begins with respect and appreciation; it must derive its strength from security, a sense of belonging, and also love (Hansen, et al., 2017). In addition to this, professional care includes performing required activities with skill and proficiency, patience and softness, sensitivity and ease. Much of the quality of medical care is the creation of a sympathetic, restful, relaxed environment that allows for maximum privacy. The European Association for Palliative Care defined "good care" for dying dementia patients as one in which patients are involved in decision-making with their families (Moore, et al., 2017). Also, during the treatment of these patients with dementia, activities that contribute to quality of life are carried out before death. In addition to this, the patient's benefit, rather than the comfort of the caregiver, directs caregivers when performing invasive medical actions, and if this is not the case, these actions will not take place, such as inserting a feeding tube. A good treatment for dementia patients relies on physical human contact, allowing for patient oral feeding rather than overfeeding using various invasive tools (Hwang, et al., 2014). Oral feeding is part of the human contact that continues the ideal spiritual care patients with dementia receive (St John & Koffman, 2017). That is, in an ideal world, treating dementia patients with sensitive and tolerant care does not prevent death at all costs by performing prolonged life-preserving actions that harm the quality of life, but treats death with dignity and enables palliative support of an elderly person with dementia (Erel, et al., 2017). But what happens when treatment is not ideal, but also far from the optimum found in treatments for other age groups?

Indeed, in reality, dementia patients often receive treatment that is far from ideal. Also, the real approach to treating dementia patients is not on the continuum between autonomy and paternalism. Some scholars argue that a widely used therapeutic approach in dementia patients, especially in old age institutions, is extremely paternalistic (Mogan, 2017). The claim is further evident in Goffman’s (1961) work on Total Institutions. Goffman argued that institutions, such as those for the elderly, that exist to achieve noble causes of individual nursing, have become well-oiled machines that crush the individual. Their main purpose is to serve as storage facilities. Elderly people with dementia do not follow the norm in modern Western society. Thus, society labels them as deviating from accepted social norms and pushes them to the social margins, alienating them from themselves, isolating them in institutions to give them "proper care" and hiding them from society (Goffman, 1961). Michelle Foucault in “The Birth of the Clinic” (1994), interpreted medicine as the most important part of modern government, it is a key part of what Foucault called “Pastoral Power". Modern Pastoral Power (medicine) is a tool of the state. The state controls this public health tool through people's activities. That is to say, the centrality of the individual's body and health in contemporary Western society makes medicine a population regulation tool, by controlling the private body in sickness and health. Physicians (caregivers in general) apply and strengthen this "Pastoral Power” and act as a state mediator between it and the individuals who are subject to supervision (Foucault, 1994). Additionally, the staff in institutions works on objects and products, but these objects/products are human. Goffman, in his work on total institutions, argued that when people are treated with materials that need to be worked on, characteristics of inanimate objects will be attributed to them by their caregivers (Goffman, 1961). Thus, through caregivers society isolates elderly people with dementia in institutions, so it is not at all surprising that researchers see dementia patients discriminated against in treatment (Erel, et al., 2017). Furthermore, the treatment of dementia patients is focused on achieving medical goals, and nursing care is limited to the simplest bodywork in treatment, such as changing diapers (Martin, et al., 2016). It thus seems that the approach prevalent in contemporary Western society towards dementia patients is not on the continuum between autonomy and paternalism. In the current reality in Western society, the treatment of dementia patients, especially those who go through the final stages of their illness in institutions, is not paternalistic, it is totalitarian. Totalitarian care turns the patient from a subject (person) into an inanimate object, disciplined and completely surrendered to his or her caregivers, reflecting not only the institution's attitude toward these patients but also the attitude of society as a whole. Caregivers of elderly dementia patients do not act for the good of the patient. Their work is born out of the necessity of social behavior towards these patients and from social expectations towards them as caregivers whose job is to keep the patients away from the gaze of "ideal" society. Therefore, totalitarian care is fundamentally inhumane (A general surgeon, 2018).

The citation of ‘A general surgeon’ in the previous paragraph requires further explanation. Despite significant technological advancements and numerous reforms, the medical system remains one of the most conservative social institutions. Its rigid hierarchical structure and paternalistic approach hinder any attempts at innovation or diversity. Physicians, nurses, and other medical staff, while aware of existing problems, refrain from voicing internal criticism for fear of jeopardizing their careers. This silencing strengthens the position of conservatives and allows the system to continue operating in the same manner, even if it is not optimal for patients. Changes implemented within the system often serve to maintain the status quo rather than challenging existing paradigms. Even senior physicians with extensive experience prefer to express their opinions anonymously, fearing retaliation from the administration.

The result is a medical system that struggles to address new challenges, fails to adequately meet the evolving needs of patients, and permits unethical behavior by some professionals. The anonymous publication of an article by a senior surgeon offers a stark illustration of the systemic problems within our healthcare system. (A general surgeon ("I am not going to sign this document. I still need my job for a few years …"). Many of the points in the following paragraphs are based on the experiences and observations of the aforementioned general surgeon.

The senior general surgeon sees the health system of the modern Western world as fundamentally a capitalist and totalitarian medical system. It pursues profit, returns and cash flow. It not only negates the person and the value of human care but also has long since destroyed the purpose for which it was created – to treat and heal. A main example of this is the modern medical institution. In our time, hospitals have become economic monsters that are strengthened by merger after merger and meanwhile provide fewer and fewer services, to reduce the economic risk inherent in providing real medical service to people in health distress. He maintained that true medicine does not generate high levels of economic profit. Medicine is created for a purpose and thus is supposed to be measured. However, in reality, a totalitarian system maintains comprehensive treatment, devoid of a human aspect, towards both the patient and the doctor. Totalitarian care is held without conversation, without any human interaction, and without emotion. A dementia patient becomes a worthless object without human form. From a person with a personal history, values, and norms, she or he becomes a "therapeutic unit" or another "occupied bed in an institution" that preserves the social situation. In totalitarian care, caregivers forget, or may not even know, who the patients were in their lives before illness and what their personal narrative is. Furthermore, in terminal stages of the illness when the patient arrives at the institution to end his or her life, their narrative is completely erased, along with their personality, identity and past. It is also a treatment that completely eliminates patients' femininity or masculinity. Although privacy is a fundamental right in patient care, for patients with dementia it does not exist, as it is not an important part of totalitarian care (A general surgeon, 2018).

Totalitarian care reduces physical contact between caregiver and patient while carrying out nursing work to the minimum that is possible and necessary. At times, the treatment is completely devoid of physical touch (un-touch care), with no human dignity, love, warm attitude nor containment. This is despite the scholarly recommendation for elderly care being "less tech, more touch" (Arcand, 2015, p. 333).

In reality, treating elderly patients with dementia is "more tech, less touch." Feeding dementia patients is a classic example of nonhuman totalitarian care that relies primarily on the comfort of the caregiver at work and not the comfort of the patient with dementia. Based on the recommendations of various studies, patient oral feeding should be preferred over mechanical feeding (Hwang, et al., 2014). In practice, totalitarian care promotes device feeding through various tools whose insertion involves discomfort, physical suffering and many other risks. Furthermore, oral feeding (or comfort feeding) is not considered and is not part of totalitarian care. Although totalitarian care is a significant part of the old-age institutions of modern Western society, it is not based on the values that this society stands for, such as: individualism, individual rights, equality, etc. Furthermore, these rights are denied to senior citizens with dementia in society. Therefore, the treatment of patients with dementia is carried out with disrespect, and even the complete eradication of human rights that naturally reach every person in modern society (A general surgeon, 2018).

Hospitals, like other social institutions, have long since become economic entities regardless of the purpose for which they were historically founded. Managed by a whole army of parasites with invented roles, with inflated managements – these medical institutions no longer engage in providing care; rather they are busy taking as much money as possible for self-enrichment and do not worry about patients. In the meantime, the number of caregivers, doctors and nurses will decrease until the number of parasites enjoying the fruits of the labor of those who stand by the patient's bedside decreases. Moreover, the number of workers in the hospitals for the most part exceeds the number of hospitalized patients, while the number of direct caregivers at the patients' bedside is being reduced (A general surgeon, 2018).

Furthermore, the treatment becomes artificial, mechanical and derogatory, and even incorporates violence and bullying by the caregivers. In addition to this, the number of caregivers exceeds their professional quality. That is, there are many caregivers without relevant education and skills. Thus, by introducing random care providers to senior institutions, total care for elderly patients with dementia is maintained (Hwang, et al., 2014).

This insight is not surprising. Modern Western society and its health systems do not want quality care or appropriate care unless it is required to maintain or maximize profits. Thus, it is logical that the caregiver over time will decline in terms of the level of quality. The health system in modern society has made the caregivers in it into hired soldiers, into slaves of the "health industry". In such a situation, it is not possible to create good care; this is a lie (A general surgeon, 2018).

Totalitarian care does not take into account the best interests of the patients with dementia or the good of their caregivers. It is a type of treatment that creates a therapeutic interaction in which both sides are victims of the social situation created. In other words, no one wants to be treated inhumanely/mechanically. Likewise, no one wants to be hurtful, humiliating, dismissive or inhumane either. Nobody wants to be a part of such care. Not the caregiver and not the patient. Admittedly, a well-oiled system also knows how to preserve itself because it relies upon the values of the society in which it exists. In other words, when a caregiver, even the most senior one, detects a fault in a system that he wants to change and begins to discuss it, he is immediately defined as an enemy of the system and is pushed to its margins. Thus, the caregiver learns that the health system, like every system of dictatorship, is not aware of the mistakes/faults and does not apologize to its workers (A general surgeon, 2018).

Admittedly, society also preserves "totalitarian care" by fostering different and separate values and norms for patients with dementia. Thus, in light of the social neglect when treating dementia patients and global aging, totalitarian care will have further negative consequences for both patients with dementia and caregivers.

Dementia patients have the right to be treated humanely until the day they die and be respected as human beings. Furthermore, caregivers must ensure an environment that supports human care and prevents totalitarian care. Thus, society must enable respectful treatment and create proper conditions for elderly patients with dementia, while maintaining the accepted values and norms in society as well as in dementia patient institutions.

This chapter discusses the concept of finding meaning in life, particularly in the context of healthcare. Thus, Viktor Frankl, a holocaust survivor and psychiatrist, argued that finding meaning in life is essential for human well-being. Even in suffering, there is a possibility to find meaning. Frankl contrasted his perspective with that of Michel Foucault, who focused on the categorization and control of patients in medical institutions. Rogers, another psychologist, emphasized the importance of empathy and unconditional positive regard in the patient-caregiver relationship. Erving Goffman explored the dynamics of power and control within healthcare institutions, including the potential negative effects on patients' identities. This chapter concludes by discussing the concept of caregiver attitudes, dynamics of opinions, and their impact on patient care, particularly for the elderly and those with dementia.

4. Specificity of modern Western societies.

The modern world is shaped by two prominent features: a focus on individualism and a culture driven by consumerism. These forces significantly influence how people live, interact, and perceive success and fulfillment. Individualism highlights personal freedom, independence, and self-expression. In today's society, people are often encouraged to prioritize their own goals, desires, and identities over collective or communal values. And, consumerism refers to the societal emphasis on acquiring goods and services, often tied to the belief that material possessions define success or happiness. This culture thrives on advertising, mass production, and a global economy that encourages relentless consumption. Fast fashion brands and tech companies encourage consumers to frequently update their wardrobes or devices, even when existing items remain functional. Advertising campaigns and influencers promote products as symbols of status, lifestyle, or personal fulfillment, fueling the desire to consume more. Events like Black Friday and holiday sales create a sense of urgency, reinforcing the link between material goods and happiness. Together, individualism and consumerism shape how people view themselves, relate to others, and engage with the world around them. While these trends promote personal freedom, creativity, and economic growth, they also bring challenges, like: social isolation, environmental concerns (overconsumption contributes to resource depletion, pollution, and waste), materialism (prioritizing possessions over relationships or non-material experiences can diminish overall well-being.). While these defining features of the modern world have their benefits, addressing their downsides requires fostering a balance between individual and collective values and promoting sustainable practices in consumption. In his book, Bauman (*Wasted Lives*, 2004) maintains that modernity engages in the unending classification of people and social groups. The nature of classification involves distinguishing between trash/garbage and necessary. To explain this phenomenon, Bauman chose to focus on three social groups. They are the absent-present of modernity: "human waste". The poor are the human garbage of economic growth, the refugees, who are the human garbage of politics in modern society, and the work migrants, who are the human garbage of globalization. According to Bauman, waste is an unavoidable outcome of the social and economic order of modernity. As society becomes more modern, it completely forgets whether these "unnecessary" people are tossed away because they are garbage or whether they are garbage because they are tossed away. In his attempt to define borders and deviation, Bauman defined garbage. In his opinion, the waste of modern society does not have essential attributes of its own. Waste is what is not classified, which interferes with the social order and has prominent external visibility. Waste is a pile of deviations from the economy, politics, and modern society itself. The people of the sanitation department are the gatekeepers of modernity. In an unending manner, they preserve the boundary that society creates between dirt and cleanliness, between desirable and undesirable, between accepted and rejected, between what remains inside and what is thrown out, between normalness and pathology, and between health and sickness. The classification, removal and destruction of waste work in all areas of society, including renewal. The desired change (any change) will be perfect only when the 'waste' is thrown away, distanced to a good distance (Bauman, 2004).

Modernity has created an ideology according to which it preserves the tools by which the individual is eliminated and erased, even in the workplace. Thus, according to Illouz (2007), the individual's workplace is a system governed by laws that obligate him to have a certain behavior and that manage the processes occurring in that place. Conflicts do not stem from competition for limited resources but from the emotional complications, personal factors, and unresolved psychological conflicts of the individual himself. Poverty, as well as other social conditions, is preserved by emotions that are created in the processes (Illouz, 2007).

The temporary and short social processes, in contrast to the lengthy ones accepted once, bring with them a meaningful change in social norms. In other words, what was once perceived as 'normal' today may be seen as pathological and requiring intervention. The new modernity adopts traits of liquid in all social domains. Also, the flexibility with which the social norms are determined causes rapid and unjustified changes that cause great confusion in society. For example, a "healthy lifestyle", in contrast to logic, is not a constant value. Its definition changes rapidly and with it the means of achieving it. Thus, modern medicine, which is directly influenced by the traits of society, is rapidly defined as an illness in different situations that deviates from the definition of the accepted lifestyle. It is possible that later, these situations that appear to be deviant will be defined as normal situations. In the meantime, medicine will continue at a rapid pace to address complications that are created as a result of medical care in situations defined as deviating from the norm (Bauman, 2008).

It is not only medicine that suffers from rapid changes in the definitions of ‘normality’. Every social field is filled with a multiplicity of information, which over time changes meanings from positive and accepted to negative and unaccepted. The creation of information, like every creation of waste, causes even more waste. Thus, the modern brain becomes ‘dirty’ with unnecessary information and begins to suffer from sticky and superfluous informational garbage. The unnecessary load of the excess of modern production in all social fields is the outcome of modern society. Thus, survival in such a society depends on skills and expertise in the removal of the ‘waste’. Waste is the embarrassing and dark secret of production in modern society. One who understands this implements, and utilizes this, lives a better life. The processes developing in modern society are not based on fundamental moral assumptions but on cost-benefit relationships that in the end make social groups superfluous and undesired (Bauman, 2008). Within the cost-benefit relationships and economic communication in society, the individual is still defined as pursuing individual happiness. However, merchandise critical and necessary for the existence of human happiness does not have a financial price and cannot be purchased in stores. Thus, according to Bauman, as long as society is managed by money, people will continue to buy and waste money in the search for the fulfillment of needs that in traditional society were provided by the care of others, love and affection. Moreover, people consciously and unconsciously choose shopping, instead of helping neighbors in distress, talking, or caring and taking responsibility for the needy. In other words, expensive gifts (objects), and tasting food at as high price as possible - all these and others are supposed to be the equivalent of happiness but they do not equal happiness and do not even draw close to it. Conversely, the requirement from purchases is to compensate for the lack of true happiness in the individual’s life (Bauman, 2008).

The new person who is created in modern society is a consumer. His consumption begins with the products he purchases, and continues with human relations, desires and emotions. Consumption, which constitutes a considerable part of modernity, prevents generosity and mutual assistance and creates an environment of loneliness. Thus, modernity has destroyed joint interests and has left the individual to cope with his private distresses. Events, and different troubles throughout life, which people are afraid of and avoid, may be the destructive power that may cause the absolute collapse of the individual’s future life. Once, social cohesion and coordination of actions that promote collaboration helped people to cope with every destructive trouble that would occur. Today, the individual copes with insults, fears and anxieties individually and independently, withdrawn and distant from the help of modern society, which is a collection of individuals pursuing only personal interests. Consequently, the world surrounding the individual broadcasts to him in an unending manner that it is not possible to rely on or trust anyone in the environment. Thus, the individual finds himself in a fragile environment entwined with conditions of uncertainty, when he cannot build in-depth relationships that lead to security in his life. In addition, distance, suspicion and lack of trust characterize all types of social relationships in the individual's life, both near and distant (Bauman, 2008). In contrast to the perception of many, to be a consumer is not an illness. Rather, consumerism is found in constant movement and development that does not end. To search and not to find, more precisely, in the meantime not to find and to continue searching is like waiting for a pleasure that has been promised and has not yet arrived (Bauman, 1998). Mental wellness, friendship and love are based on individual consumerism. Therefore, giving a present (a purchased object) causes the individual a feeling of happiness. In other words, it appears that an object is equal to bringing happiness. Modernity enroots in people the belief that there is a clear relationship between happiness and consumerism. Modern society urges people to run from store to store and buy more objects, most of which are not needed at all for a happy life and even for consumption. People in society buy without looking inwards, into themselves, exactly in the same way as buying something superficially. People search for happiness in the stores, instead of looking inward and searching for a reason for happiness in the close relationships that need to be built, love that needs to be found, and mental wellness that needs to be cultivated. Modern society does not leave time to stop to think and look. It has long developed in people a dependency between happiness, which is not real, and the quality of consumption. The more people buy, the more happiness people obtain (Bauman, 2008).

The consumerism of happiness derives directly from emotional capitalism. Modern society long ago eliminated all existing boundaries between emotion and economics or consumerism. Positive emotions, such as happiness, are characterized by something material that can be held in the hands or purchased in a store. For example, it is enough to demonstrate concern and attention towards workers in a material way (such as giving gifts), to boost work productivity (Illouz, 2007).

According to Giddens, distance and suspicion push people to create in their surrounding world relations of trust that are so important for survival in modern society. In his opinion, in an environment filled with risks, like in modern society, people without relations of trust cannot build a personal identity. In addition, life in society, even in modern society, is based on reciprocal dependence. Therefore, relations of trust between people constitute emotional immunization against anxieties and fears. Furthermore, a feeling of trust between people in society constitutes a source of social stability and personal integrity (Giddens, 1991).

A sense of emotional protection and the ability to trust the environment helps individuals recognize the emotional differences of those around them and accept them without question. These abilities among people create values of equality and fairness in society. In addition, the different emotional resources that are mobilized at the right time for social processes make it possible to extend society's existence with stability (Illouz, 2007). In addition, in Giddens' (1991) opinion, relations of this type constitute something whole, without the need for external support. For individuals who are found in a relationship, the value of these relations uniquely and exclusively derives from their content. Thus, in contrast to traditional society, in which every relationship is based on mutual reflection or ignoring one another, in modern society the relationship depends on cooperation and management of negotiations. From now on, the relationship is built on content and individual identity and not on shared identity and mutual benefit (Giddens, 1991). And this is not at all surprising. The right to an individual identity constitutes a basis that unites people in modern society. There is no longer a need, as in the past, to search for sources of power around others. It is enough to look inside and find the missing things (Bauman, 2001).

Cooley (1902) gave a place in the individual's life to two types of attachment. According to him, the individual belongs to two groups. The primary group is the nuclear family and the immediate community. The relationship between this group and the individual is a derivative of the expression of warmth and love, support and concern. These are emotional relationships and not transactional ones. The secondary group is significantly broader. It is based on an instrumental relationship and is characterized by formal life, which is bureaucratic and organizational. In his opinion, the individual builds his 'self' and receives reflection and appreciation from those around him. The instrumental relationships, which characterize the secondary group, are cold relations, devoid of emotions. The individual is evaluated according to performance, and his place in the social status. During the interaction in the secondary group, the system of those around says to the individual who he is. The individual's 'self' assumes a certain value, with which he continues the following interaction with the other selves (Cooley, 1902).

According to Bauman, an individual grows up and is strengthened in a society in which nothing is truly necessary, everything can be changed, and what is exchanged is removed and thrown out. An interpersonal relationship, loyalty, love, friendship - everything has a clear expiry according to which the individual's life in modern society is run. Thus, relationships, living together, end within two years (in England about 40% get a divorce). Interpersonal relationships, even the closest ones, are characterized by superficiality and fragility. According to Bauman, this issue is not at all surprising. The society of consumers operates according to constant and unending consumption. What was good more easily becomes bad or not suitable. Modern society has created for itself a "casino culture". People in this society attempt to make every round into immediate and maximal benefit, and when the issue does not succeed the individual searches for the next round (Bauman, 2004). Giddens broadens Bauman's argument. He maintains that an individual constitutes what he has created from himself with his very hands. He is led by the identity he creates for himself. An individual paves for himself a unique path that is influenced by his personal life processes more than by events that occur in outside society. He is troubled by his economic difficulties or his fear of unemployment and not by what is happening in society; namely, a wave of terminations does not bother him until it pertains to him personally. In addition, modern society creates an abundance of opportunities and enables individuals to make choices. The process of choice is not easy. However, for personal development, the individual must have stability, opportunity, and moderate risk. Thus, the achievement of the individual realization obligates the individual to separate between main things and trivial things and to stick to the truth as he interprets it without dependence on social interpretation (Giddens, 1991). Beck also sees the reality similarly. In his opinion, many tend to think that the disintegration of the old structure and social order, which were based on status, religion and traditional family, must occur at the end of the road to economic and social collapse. Therefore, ethics of self-fulfillment and personal responsibility constitute, according to Beck, some of the most impressive and significant achievements of modern society. The individual builds himself and thus creates freely the story of his life, which creates his identity. Thus, more and more people measure their social self-development according to society's ability to enable an opportunity for development according to the values of the individual's personal life. However, Beck (1992) sought not to confuse social moral individualism and consumerism as Bauman presented (Bauman,1992).

Culture is not only a basis for the individual's existence in human society. It is an important creation of humanity, and it is what manages current society. Therefore, Bauman maintains that norms of modern culture are supposed to cause people to internalize that the interpretation of the art of life is the construction of individual happiness. However, modern liquidity still cannot define the concept of human happiness. Furthermore, the status of happiness changes all the time, and its content is too diverse and changes too frequently. Only one thing is constant: happiness can never be achieved. Nevertheless, as long as the person believes in his ability to achieve happiness throughout life, he will continue to move forward (Bauman, 2008).

Modernity itself changes the culture according to the needs of liquidity. Thus, for example, the importance of the meaning of life no longer exists. Instead, there is a clear hierarchy of people in culture. In other words, people are divided into important, less important, and not at all important, in modern culture ('casino culture') there is the elimination of values. All that was esteemed in yesterday today is no longer important and tomorrow will become trash that nobody needs. Modern culture believes in "living the moment", namely, not exercising restraint, and not saving for years. The consumption that is essential in contemporary culture teaches us to think about personal enjoyment alone, even when buying a gift for another person. Alongside the lack of meaning to human life, the meaning of time changes absolutely. Thus, waiting in line becomes pleasant because of the use of electronic gadgets at our disposal and not because of interpersonal conversation without screens between strangers in waiting rooms. Gadgets have made interpersonal communication easier, and less obligating. Thus, the ability to build spontaneous relationships with real people has been lost. Hiding behind the screen helps people not go in-depth and remain superficial in feelings, thoughts and emotional investment in another. In actuality, people in modern society avoid contact with real people in the environment, including in the waiting environment, shorten communication, do not look into others' eyes, and hide behind screens. Social networks easily enable a person to connect to or erase friends, without the need for any social skills. Social interaction has changed irreversibly (Bauman, 2004).

In addition, culture in modern society is not at all based on values. Therefore, prohibitions that were known in traditional society today have become temptations of consumption. When the consumption does not bring with it the feeling of happiness that was promised, the individual easily blames the incorrect choice of the opportunity that he made and continues to search for additional opportunities without drawing conclusions or thinking too much on the topic. This approach characterizes the individual's conduct in both the private and the social arena (Bauman, 2008). It is easy to blame society for posing temptations in front of the individual. The time has come to accept the nature of temptation - it is found for a person who seeks, the desired consumer. The temptation itself is devoid of meaning. It cannot be positive or negative. Temptation that characterizes modern society is a power or requirement to move forward. And this power is too strong to resist, and the individual in society submits to its forces. And this submission to the sweet power of consumption enables the individual to collect experiences while being mobile. Thus, artificially a feeling of lack of satisfaction is created from what is in the hands. The lack of satisfaction strengthens the consumer temptation to move for the achievement of new products that can be defined as being prestigious (Bauman, 1998).

The only thing, according to Bauman (1998), that has value in modern society is mobility. Now, it is possible to describe everything in society from the perspective of mobility. In other words, as society is more mobile, it necessarily is more modern and it has greater chances to survive in the liquid modern world. One who is mobile and has mastered mobility is free. The ability to move enables the control of others, the control of the creation of opportunities and choices. The period of mobility is the end of geography in its traditional sense. Distances between places have lost their meaning in modern society. In addition, as mobility is easier and accessible to a greater number of people, the idea of geographic borders between states also loses meaning, to the point that it is harder to maintain the borders between the states, with all the attendant implications. Modern society has revealed that the separating lines (the borders) that had existed on the continents between the countries are only a function of distance and people's ability to move from place to place. Distance in the modern world is no longer a physical datum that is measured with a simple value. It has become a social product, another product of daily consumption, which is measured by the speed at which the individual advances and the cost of the speed of the progress for him. People in modern society are nomads, who move from place to place to search for their social happiness. However, this is not a homogenous group. It is divided into two: some people actively travel around the world, while there are people who look at the world that passes alongside them. (Bauman, 1998).

Beck (1992) also agrees with Bauman's argument. In his opinion, competitive boundaries are accepted between places of production in the world and geographical distances lose their importance. In other words, the economic processes lose their geographic positioning and cancel the convention according to which it is necessary to act together in a certain place. Thus, the new space (without spaces) creates closeness through the developing technology, for the construction of a competition shared by all the places of production in the world over the diminishing investments of capital and the cheap and available workforce. According to the modern equation capital is global and work is local. The global economy is based on the ability to reduce distances and organize in real time a segmented work process. This is expressed in the almost immediate change in the basic structure of society. In the past twenty years, society has seen the appearance of a new type of economy (Beck, 1992). This type of economy was called by Castells (2010) the global economy of information, because today output and competition between different economic factors depend first and foremost on the ability to efficiently produce, process and utilize knowledge-based information. Furthermore, Castells defines the economy as global since the main economic activities (such as industry, consumption and cycle of products and services) and its components (such as capital, production materials, information management, markets, technologies and information) are organized on the global level. Also, the economy is perceived globally, since it can work as one whole system at a current given unit of time on the level of all the countries of the world. Nevertheless, protectionism and restriction of free trade among countries and markets of products and services have become more and more global (Castells, 2010).

According to Bauman (2007), the individual is found constantly in a situation of human suffering or fear of the suffering that will come. Therefore, the individual's main energy is invested in the treatment of fears and anxieties. Modern society causes the individual to prefer self-care, self-help, over the choice between opportunities, evaluation of risk, or care of others. Thus, the management of fear yields, on the level of society, even more fears and anxieties and their enrooting (Bauman, 2007). The preference for self-care, the absence of the desire to care for others, the ignoring of altruism - all these and many other attributes are interpreted in modern society as individualism. Rather, the opposite is true; they are the indications of a modern culture that has grown on the elimination of giving behavior and fears. For example, a cancer phobia is identified with fear of a polluted environment that can cause changes in the human body. The altruistic model of behavior in contemporary society, for example, providing blood anonymously, is no longer possible. Today it is clear that body fluids carry a high mortality potential, and therefore naturally the public wants to know who is donating to be protected from certain diseases. In other words, the phobia of being infected with AIDS or another disease no longer allows altruism in a voluntary and anonymous donation. For the same reasons, most people prefer distancing themselves and avoiding situations in which they will be required to care for a patient who has a dreaded sickness that is incurable. The risk of being harmed is real and known ahead of time. Thus, the self-care and self-concern, through the avoidance of helping one another is the new value of contemporary modern culture that not only ensures the individual's survival but also results in additional new phobias (Sontag, 1989).

4.1.Globalization.

Modern Western society is found to be under the influence of a variety of processes and different social phenomena simultaneously. The main phenomenon is globalization: the broadening and the deepening of the cultural and economic relationships between countries, societies and individuals. This connection creates a close integration of cultures, political and social movements, and economies. This situation causes reciprocal dependence, and thus influence on one another is intensified. Throughout the history of human development, the trend of sharing resources, such as knowledge, information, human resources, and technology, steadily strengthened. This phenomenon makes unique countries base themselves on shared values and norms and creates one culture for all. This process entails the nearly absolute elimination of the uniqueness of every state separately. In addition, different social phenomena strengthen and acquire for themselves the ability to broadly influence all the countries and societies found under reciprocal relationships, whether based on geographic or cultural closeness (Sherif Trask, 2010).

Bauman (1998) maintained that “globalization” today is found in fashion, is a modern slogan, or even a key to many puzzles in the present and in the future. For many people, globalization is necessary for the feeling of happiness like air for breathing. But some blame it for all the troubles of the world. However, there is one shared basis for all these people: there is the belief that globalization is a complete and inevitable destruction of the world that has been known so far. Moreover, it is a process that will affect the lives of each and every one, without exception (Bauman, 1998).

In the opinion of Giddens (2000), the spread of the concept of globalization itself proves the scope of the phenomenon. Thus, for example, the global market lost its national borders and its belonging to a certain country. When the discussion of the phenomenon focuses solely on the economic field, it may lose the ability to objectively map the true influence of globalization, which is a multidisciplinary and multifaceted phenomenon (Giddens, 2000).

Globalization is not an unequivocal phenomenon. It builds and destroys, it unites and it separates, creates crises, and concurrently attempts to find solutions. For some people it is a gift, for others, it is a terrible tragedy. In addition, it brings with it many changes, not only in the familiar institutions and social phenomena, and it intervenes in the individual’s private life. The feeling of lack of control and lack of certainty that embraces the entire world, the confusion of concepts, and lack of clear definitions of phenomena in society - all these express the essence of globalization. The profound idea of globalization lies in its independent character that is not possible to define and is expressed in the lack of a center of control; a committee of managers who decide or a main branch that makes decisions regarding all the rest of the branches. Globalization is a new social order, if it can be called that, a social order that is characterized by general chaos, lack of certainty, and many changes (Bauman, 1998).

Beck (1992) did not see globalization as a social phenomenon. According to him, this is a framework that interprets in a new way the state, politics, society and culture. Globalization increases the mutual external dependence between societies of nation-states that continue to exist. However, institutions and transnational factors are required as a super-structure. In addition, existing multicultural identities disrupt the order of national societies organized as states. Thus, the view of globalization as a supra-structure, above nationality, above the state, and society, only empowers the meaning of the changes and the risks that develop in modern society (Beck, 1992).

One of these risks is the use of technology. However, the use of technology and science enables processes that occur in society to spread more rapidly. Thus, around 150 years after the invention of Morse code, it stopped being used among seamen and was replaced by satellite communication that allowed the transmission of more information at higher speeds. Every additional wave of innovations in media increases the pace of the transfer of information between people and increases the impact of globalization on the world. Thus, in the United States about forty years were required to increase the number of radio listeners to fifty million. However, the number of personal computer users reached this number in fifteen years after the personal computer entered the market. But when the Internet was created, the number of users increased to fifty million people as soon as after four years. Yet it is a mistake to assume that globalization pertains only to large systems. It enters the individual's life and influences all areas in it, even the most intimate (Giddens, 2000).

Castells emphasizes the positive impact of the development of technology and compares this influence to the Industrial Revolution in the 19th century. The technology penetrates all areas of both personal and social life. Technology is not an outside source of influence that is disconnected from the process. It constitutes material itself, and in it are entwined all the innovations with influence. The current technological revolution is not characterized by the main role of knowledge and information. The main factor around which the revolution is built is the use of knowledge and information rapidly for the creation of knowledge and the processing of information using technologies of innovations. Thus, easy access to innovative technological means, speed of processing, and the manner of offering the needed information to the individual extend and strengthen modern human thinking. The manner and content of contemporary thinking that was created by technology are expressed in products, services, materials and intellectual products, such as food, residence, transportation, information and communication systems, computers, education, and health. Thus, the steadily increasing merger between technology and thought, including the use of human DNA, reduces the gap between machines and man. This innovation changes essentially and irreversibly how people are born, live, learn, work, create, consume, dream, fight and die. It is important to note that technological innovations and rapid development of the ease of access to these technologies do not exist in a way isolated from processes that occur in society (Castells, 2010).

Globalization leads to the creation of new types of reciprocal relations between individuals and societies. These reciprocal relations create a difference in the nature and character of traditional social institutions. One of the most important social institutions changing globalization is the family. When the family, as a social unit, changes, it causes a transformation in the perception of marriage, parenting, singlehood, aging of intergenerational relations, childhood, division of roles, and so on. Parallel to the change in the traditional form of the family circle in modern society, there is a transformation in the status of women in society. Today, not only does the family create a comfortable basis for the departure of a woman to the job market but also society itself creates economic, political and cultural conditions suited for this (Fine, 2012; Sherif Trask, 2010).

Moreover, the traditional family is now undergoing rapid changes that are already in their infancy, thus significantly limiting the emotional support and care it can provide. Phenomena such as economic migration (abroad or to other cities), the increase in the employment activity of women, the increase in the number of divorces, and the disappearance of multi-generational families naturally reduce the potential of caring and the emotional capacity of the family as a whole (Beck, 19992).

Globalization has negated the autonomy of nation states. Conversely, it is the reason for the rise in national cultural identity in many regions around the world. Thus, Giddens continues to search for reasons why Scotland is demanding independence and separation as a response to processes of globalization, just like local nationalism in other places in the world. Globalization develops horizontally. It creates new economic and cultural areas in one state. However, other phenomena also become apparent, such as, for example, the poor becoming poorer and the rich becoming richer– significantly so. Also, large companies sell harmful products in developing countries, for profits that were not achieved. For the most part, these are products that were prohibited for marketing and sales in developed countries (Giddens, 2000).

In addition, social phenomena influence and are influenced by different social processes. In other words, the variety of norms and values that constitute an outcome of changing culture, such as freedom, equality and individualism, is translated into a range of new ideas, according to which the role of the man and the woman in the family and in society are re-examined, intergenerational relations are measured, the value of traditional institutions in society is considered, and the role and functioning of the elderly person in the family, the community, and society are re-evaluated. In other words, despite an essential change in the structure of the family, the nuclear family remains a significant institution in modern society, in contrast to the description of the disappearance from the world of the family circle as it appeared in older research works (Korkmaz Yaylagul & Seedsman, 2012; Sherif Trask, 2010).

According to Beck, the family constitutes a prototype of solidarity. This is solidarity that is not focused on instrumental transactional relationships and power but on affective (emotional) relationships. The view of the family in terms of the job market as an organized unit that provides care and promotes collaboration in the making of decisions is not correct (Cooley, 1902; Beck, 1992). Unlike working for a salary or reciprocal relations in social frameworks, family activity is directed at defined others (family members) and their needs and enables benefits that are not assessed according to financial return. The concern for each member of the family is provided as obvious and without the need for additional guarantees. In other words, according to solidarity in the family, even the weak (the elderly, the sick, the young) have the obvious right to receive all the care and activity needed. However, it is not yet known how the family will be influenced by individualism, and whether this structure, as known today, will survive the process at all (Beck, 1992).

Giddens (2000) broadens Beck's assertion. He maintains that, as far as is known today, there have never been societies in which the status of men and women was equal. Thus, in his view, contemporary society is a witness to a social revolution that is taking place at high speed. He emphasizes that of all the changes that are occurring in society today, the most important change is the change that concerns the individual's private life - sex, romantic relationships, marriage and family. The changes in the equality between the sexes will change the family significantly and unequivocally (Giddens, 2000).

When speaking of the new roles of the family, especially the elderly, it is necessary to bring up for discussion the issue of the neglect of the elderly in the family circle and the lack of intervention on the part of society for the repair of this situation. The neglect of the elderly derives not only from the lack of ability of the family to bear the traditional duties towards their aging family members but also the absolute absence of social institutions that can take upon themselves duties towards the elderly instead of the family (Itula-Abumere, 2012).

Other researchers maintain that not only morality or taking on roles that historically were filled by the family are what influence the concern and caring regarding the elderly. Today a family no longer bears the responsibility towards the elderly as was accepted since time immemorial, in contrast to social ideology, accepted also today, according to which the elderly are supposed to grow old at home. However, when there is a decline in the physical and health situation of the elderly person and a rise in his dependence on others for the purpose of everyday care, the elderly person is conveyed to special residences for seniors. This phenomenon occurs despite social ideology and the preference of the elderly person himself to grow old and to die at home among family. In Switzerland, the decision regarding the transfer of the elderly person from his home is made by the family. When the elderly person’s dependence on others to perform everyday activities increases and his physical and health situation worsens, the family members feel the harm to the quality of their life alongside their inability to provide appropriate care for the elderly person in the family and decide to transfer him to the institution. The situation that is created calls for the aging people and their family members to internalize that the end of their life at home, among family, is barely possible in modern times. Health systems around the world must be prepared for an increase in their involvement in the care of and concern for the elderly during the rest of their lives and take up the responsibility instead of the family. Hence, a change must be performed in the social perception. Family relationships, which until now were perceived as a safety net, are not defined in modern society as such when talking about the elderly (Soderberg, et al., 2012).

When attempting to map the uniqueness of modern Western society, Korkmaz Yalagul and Seedsman (2012) recommend seeing it holistically, without separation from social institutions and adherence to the general aspect of the issue alone. In their opinion, analysis of social phenomena separately one from another does not lead to true insight. The separation that exists today harms the ability to assess social phenomena correctly. In other words, it is not possible to see the process of aging in isolation from other periods of the life cycle. Aging is a part of the life circle. Therefore, it is necessary to see it as a part of something whole, depending on other parts, influenced by and influencing the other periods in the person’s life. In addition, every culture can be assessed in the context of the system of values and norms in the society from which it grew.

On the level of the individual, aging constitutes a significant personal phenomenon, since aging emphasizes the physical ability to survive, the psychological ability to adjust to changes, and the social ability to realize and fulfill a variety of social roles. One individual is different from millions of others, because of his way of thinking behavior and perception. He is only a single part of a holistic picture of an entire society. In addition, a view according to which old age is a period isolated from the rest of the periods and is identified in an absolute manner with poverty, disease and lack of abilities in a variety of areas, is not correct (Korkmaz Yaylagul & Seedsman, 2012). Therefore, alongside it being an individual phenomenon the process of the aging of the population constitutes a social phenomenon. Although this process is shared by the entire world, in Western society aging will play a serious critical role very soon. For the first time in human history, the percentage of the elderly will exceed the birthrate. Hence, modern Western society will need to cope with the need for a re-definition of the role of the elderly person in society. As a part of this interpretation, age, and old age have profound cultural meaning, according to which there will be the interpretation and creation of new values and norms instead of a traditional approach that does not differentiate between the chronological age and the physiological age of the elderly and see the elderly as a homogenous social group, although it is not. Due to environmental, cultural and social processes (such as migration), the elderly in modern Western society constitute a steadily increasing multicultural group which poses a variety of challenges to society on a political and social level (Bai, 2014; Sherif Trask, 2010).

When speaking of the main phenomena that characterize modern Western society, it is necessary to note internal and external migration. Its influences are especially decisive, when possible changes along with globalization and aging are estimated. Today one in three people in the world is a migrant. About 15% of the population of Switzerland are migrants. The number of migrants above the age of 65 is estimated at 217,000. The situation is similar in the rest of Europe. The population in modern Western society in the future will become multicultural and multilingual. Alongside the constant aging and consistent decline in the birthrate, in the future, health systems will need to cope with a multicultural elderly population that requires diverse and multilingual medical services (Hadziabdic, et al., 2015). Therefore, it is not surprising at all that the shapers of political social policy, especially in the field of health, see the situation created as a disaster, a burden, and a low point that will characterize modern Western society in the future. The gloomy perspective on this situation is further worsened because of the poor quality of life among the elderly that today characterizes most of the adult population in the Western world. Thus, a paradox is created: Western society is aging but is not suited for the elderly. Today society does not grant social and economic security to the elderly, regardless of their physical situation, social status, and resources that were accumulated during their lives. In addition, most of the elderly population in Western society, including those who were economically stable in their youths, cannot maintain their socioeconomic level at the same level until they die because of their increased longevity. Therefore, poverty is a main characteristic of the economic situation of the elderly in society (Itula-Abumere, 2012).

No society in history has experienced the aging of its population until now. Modern Western society will learn and adjust to the process of aging, which it is experiencing today (Hadziabdic, et al., 2015). And, when analyzing aging as a social process, Luszczynska (2021) suggests focusing on the phenomenon of the feminization of old age, which is manifested in the numerical dominance of women. In her opinion, feminization has critical social and political consequences, for example, regarding revenue policy. In Poland, for example, women’s pensions are on average lower than men’s. Another example is health policy, with women’s self-esteem regarding their health generally worse than that of men of the same age. Another phenomenon that characterizes aging is singularization. According to projections from the statistics in Poland, in 2030 up to 53.3% of households will be of individuals and run by people aged 65 and over, including 17.3% managed by seniors aged 80 and over (Luszczynska, 2021).

Many years of employment and social and economic security before retirement do not always enable an economically secure future in old age. In other words, economic well-being during old age, which a long time ago became the obligation of governments, employers and social institutions, no longer grants material well-being at a late age. Moreover, it is expected of every elderly citizen to personally see himself economically through the investment in personal pension plans. The everyday care of the elderly, the filling of basic needs, and mental well-being are assigned to his family. It is important that when the family is expected to fulfill the roles of society for the elderly person in most situations these roles are fulfilled by women who are forced to surrender their entry into the job market or who assume upon themselves further responsibility. This trend rises in parallel to the aging of the population (Beck, 1992).

This data is not at all surprising. Beck maintained that the division of labor in society, as well as in the household, is not equal in a radical manner. In the family, the duties assigned do not come with rights. In actuality, the division of the burden is carried out according to a principal contradictory to equality; like in general society, so too in the family. In other words, according to the division of roles in society, women are the ones who generally have the duties and lack the rights, such as the right to personal development, space, time and money of their own. Conversely, the ‘helplessness’ of men rises, such as not doing anything (especially at home), demanding care in various situations, to wanting to decide on any matter, even on issues not directly related to them. This extremely unequal division is retained strongly even in Western, industrial, non-religious and non-traditional societies (Beck, 1992).

According to Illouz (2007), modern society requires women to both judge and be judged. Furthermore, they are constantly encouraged to merge in their personality two conflicting value systems: on the one hand, the concern for others and their cultivation, and on the other hand, autonomy and independence (lack of dependence). Thus, little by little, men and women go through a process and may one day be equal in the deepest sense of the word. Indeed, men and women must understand that they will not achieve the pleasure that both parties crave as long as they do not understand that the most satisfying sex is not something that a man does to a woman or a woman to a man, but something that a man and a woman do together as equals in society (Illouz, 2007).

Inequality and a variety of prejudices and stereotypes create a large gap between what is expected in society and the situation in reality. Society projects its situation on all the institutions in it. Therefore, a family reflects precisely what occurs in society. In the developed Western world, when the work of women is not properly appreciated and there is a social expectation for the woman to assume upon herself fully the tasks in the home, naturally it is expected of girls (and not boys) to take upon themselves the care for the elderly in the family (Sherif Trask, 2010). Korkmaz Yaylagul and Seedsman (2012) agree with this argument and hold that traditionally in Western society the man is perceived as holding the dominant position in the job market in comparison to the woman, who is supposed to exclusively have responsibility for the care of the children and the performance of the housework, including the care of the elderly in the household. Even when the woman goes to the job market, her situation at home does not change. In other words, the status of the woman in the household, like that of the man, has not essentially changed in comparison to the past. The care and concern for the family, relatives, and friends have always characterized human society. The gender separation in the roles in the family and society continues to characterize modern Western society exactly as it did in the past. Traditionally, a social group is created of married women and unmarried women who provide care informally without salary. However, today there is a demand for a new solution. There is no doubt that the care of children, the elderly and patients in the home is an asset essential to the existence of human society. However, the following question is asked: who will take upon himself the non-formal roles without payment in a contemporary changing society?

One of the main roles of this type is the care of the elderly. Practically most of the elderly need help in the performance of daily tasks in the home, and therefore there is the need for the continuous presence of a caregiver. However, a high percentage of women in modern Western society work outside of the home for pay and already do not fulfill roles of care in their homes as expected in the past. Despite the improvement in women’s status in modern Western society, the care of the elderly remains as it was in the past the province of women, whether this is work for wages or the fulfilling of this role in the home. When speaking of the care for the elderly in institutions or at home, women still constitute the main workforce. In contrast to what was customary in the past, many women prefer to offer their labor in the field of services (especially in the care of the elderly and children) outside of the home, to receive a salary for their work. Therefore, men more and more are taking upon themselves the role of the care of parents and children, at least in a partial manner (Fine, 2012).

Moreover, as the percentage of the elderly in society increases, in parallel to the decrease in the birthrate, the risk of economic harm during old age steadily rises despite personal financial investments in old age during life. Thus, in modern Western societies, it is more and more common that an elderly person who only has minimal pension funds after he retires will live in poverty and economic dependency. Thus, the perception that an elderly person in society is well off and has quality leisure time will soon be replaced by the picture in which old age is a threatening and dangerous situation. Today, modern Western society looks at the population of the elderly through a capitalist model, according to which the group of elderly is a social group with low output and low value in the job market, and in addition, the dependence that it developed in the overall population disrupts development. Such a perception of the elderly creates many stereotypes in the population, cultivates discrimination and harms the social equality of the elderly in society, with the complete elimination of the complexity of the experience that the elderly have accumulated throughout their lives. The time has come to look at this social group up close and to understand that the elderly are a diverse population, with different groups. Some elderly people can care for themselves, but some require help. Some elderly people possess means, while there are elderly people who struggle financially. Some elderly people are healthy, while there are elderly people who need complicated medical treatments. Some elderly people need considerable social support, while there are elderly people who are supported by their families till their death without any assistance in society and its institutions. The fear of dependence in old age steadily grows stronger, with negative influences both on the level of the individual and on the level of society. The decrease in retirement funds and an increase in the lack of stability and financial security before retirement exacerbate the family and social dilemma on the question of how to care for helpless family members when the financial resources are scarce and are steadily and rapidly declining (Sherif Trask, 2010).

Thus, negative stereotypes begin to be created and produce a negative image of the aging generation. In other words, the image of old age in modern Western society, in comparison to other age groups, is negative. There are research studies that prove this through analysis of the television programs broadcast over the years. For instance, as of 1984, only 3.1 characters who appeared were above the age of 60. Today the percentage is similar. In addition, forgetfulness and rigidity are the main character traits presented in the elderly characters presented on the different television programs. Furthermore, the elderly are presented in the general media as negative characters devoid of physical, cognitive and mental abilities. The impact of the media is especially destructive in social groups with the interaction of a low frequency with the group of the elderly. Research studies show that in these groups old age is perceived as causing general harm to abilities and the elderly are perceived necessarily as sick, physically and mentally slow, forgetful, troublesome, unproductive, sexually inactive and so on (Bai, 2014).

While older people may sometimes be directly excluded by others from certain areas of modern social life and do not feel a sufficient level of support or acceptance, the elderly are automatically marginalized and distanced by themselves as well. This is how they exit from the labor market, withdraw from social life, stop spending their time in active pursuits and end their engagement in joint initiatives and social projects. They close in on themselves. Furthermore, they are rejected by society from receiving the goods and services that everyone else receives. Also, the elderly are discriminated against not only by other people and their social groups but also by public institutions. They see themselves as unnecessary, weak and useless citizens who take someone else’s rightful place in the social order. When thinking of the elderly as one set, it is clear that the elderly are a very diverse group. Namely, the elderly have different life experiences, levels of health, degrees of physical and mental fitness, family situations, attitudes to life, educational background, financial situations, professional experiences, social life, interests, needs, skills, ways of behaving, future plans, civic maturity, and desires influenced by their world view, which is so diverse (Luszczynska, 2021).

The personal image among the group of the elderly about old age is also negative. This negative image of the group of elderly draws its strength in the belief according to which the individual from the moment of his entry into the elderly group appears to have chronic illnesses with deteriorated cognitive, mental, physical and social abilities. This type of belief builds stereotypes and entrenches them in society and leads to the development of discrimination based on age (ageism) (Bai, 2014).

Margaret Mead, based on the cognitive theory of aging, maintained that the elderly internalize throughout their lives the social stereotypes about old age. In her opinion, through continuous exposure to negative stereotypes about old age, when one reaches old age, the individual acquires for himself a feeling of lack of fitness, lack of efficacy and low self-esteem (Mead M., 1973). Thus, these traits become a part of his personality during old age. As the elderly person has greater reciprocal relations with people who hold a negative opinion of old age, he will tend to internalize and adhere to a negative approach to old age and the elderly in society. Inadequate exposure to positive information on old age causes the absence of the assimilation of a positive perception and consequently, the adherence to negative stereotypes steadily increases and causes the old person to be more judgmental towards the elderly who have positive attitudes towards old age. Moreover, the elderly person tends to compare himself to the ‘existing elderly’ from the stereotypes. When his situation appears to the old person to be more positive than that of the ‘existing elderly person’ in the stereotypes, the old person will tend to hold onto and adhere to the stereotypes. However, when the elderly person’s situation is appraised as less successful than the stereotypes, the elderly person will tend to decline in self-esteem even further. People with a more positive personal viewpoint are happier and in their old age are healthier. In this situation, the individual acquires for himself an optimistic perception that has implications for his perception of aging (Bai, 2014).

The individual, from the day of his birth to the day of his death, is influenced by two worlds: external and internal. The internal world is characterized by personal perceptions, self-image, emotions and level of motivation. The external world is composed of the physical body of the individual and the environment. True understanding and acceptance of the elderly person as an individual in society see the elderly person as an individual who thinks, feels and makes decisions in his environment that changes constantly according to his body that is changing physically and biologically. Modern society must see the elderly person holistically as an individual with physiological, psychological, spiritual and social requirements in one vessel. Aging naturally constitutes a personal and social process at once. However, modern Western society does not see the elderly person holistically and thus strengthens stereotypes and prejudices about the elderly (Korkmaz Yaylagul & Seedsman, 2012).

The strengthening of stereotypes and the birth of negative social phenomena such as discrimination against a certain group eventually harm society itself. Discrimination on the basis of old age, as well as a negative perception of old age in general, is destructive when looking at the future of society. A positive perception of the elderly in society enables the improvement of the image of old age. A positive image of a social group, especially the group of the elderly, enables the effective utilization of the human resources found in this group for the different needs of society, the involvement of the elderly in social activity, and the prevention of abuse and/or poor treatment towards them (Bai, 2014). Alongside the development of a unique policy towards the elderly, it is necessary to be careful about the creation of communities for the elderly alone, since alongside the desire to fulfill the elderly people's needs there may be a deepening of the gap between the elderly and other age groups and a worsening of the discrimination against the elderly. An appropriate solution will be to involve young people in communication with the elderly, to perform joint projects, and to integrate the elderly in the general population, without isolation based on the health situation or physical limitations following age (Itula-Abumere, 2012).

A positive social image contributes to a positive personal image in the elderly age group. In other words, when the social image of the elderly group is positive, the elderly not only perceive old age positively but display better memory and hearing. In addition, the elderly who perceive old age as more positive suffer from a lower rate of cardiovascular disease than the elderly who do not perceive old age as positive. A reduced rate of depression and a strong desire to live and be socially active characterize the elderly with a positive perception of old age. In other words, the empowerment of the elderly in modern society not only will improve the process of aging for everyone but will also destroy the creation of stereotypes that cause society to ignore the resources existing in it, leading to the building of a better life for all of society (Bai, 2014). Margaret Mead (1973) argues in her book that aging is a process the individual experiences naturally in his life and therefore to avoid it is possible only if people avoid growing up. People need to understand that life, in all its stages, is a natural and developmental process that ends only in one case – death. Society can no longer ignore the specialness of each old person and link all the elderly people in the population to one group based on biological age alone (Mead M., 1973).

Prejudices, social stereotypes, and lack of education or tolerance towards different groups lead to the creation of social inequality between certain social groups. In the opinion of many researchers, modern Western society is a society that cultivates social inequality between the groups in it, especially between men and women, young and old. Therefore, it is natural that social discrimination, along with prejudices, gender, race, nationality, and lack of equal opportunities, comes to a head at advanced ages. In other words, throughout life the individual copes with different types of inequality, and when he grows old and retires from the job market, he experiences poverty, low status and consequently vulnerability. This situation is especially prominent among women, whether they are employed or whether they have retired from the job market already.

The assurance of opportunities for higher quality of life in old age is essential to the individual's good aging. Good access to economic resources after retirement from the job market enables the achievement of better health and preservation throughout many more years. However, when during youth the person has a lack of livelihood or a limited livelihood without payments for the period of old age, the individual's sense of security is harmed significantly and there is a high cost to his health, both in the present and the future. Lengthy absence of livelihood exposes the individual and his family to long periods of tension, frustration, and lack of functioning on a family and social level. In many cases, when this is a primary or sole breadwinner in the family, the economic damage is more significant, and as it lasts longer the situation becomes irreversible and its implications are more negative to the health of the family members. Therefore, there is a strong desire for a pension fund and even a pension fund independent of the person's economic ability in his young life. Pension funds known today in many countries do not constitute a basis for economic security in the future. Pension funds are not trustworthy, and are not equal between the workers who pay in, and as a result, many elderly people live under conditions of abject poverty that do not allow them to meet their basic needs of life, such as food, residence and medical services. A pension is supposed to allow the elderly person the economic capacity to live with dignity after retirement from the job market (Korkmaz Yaylagul & Seedsman, 2012).

This situation is also similar in Poland. The Polish elderly cannot afford trips, entertainment activities, and the purchase of luxury items, such as jewelry, perfumes and high-end electronics, not to mention the purchase of a car or an apartment. Despite their regular income, their financial situation does not allow them to spend money freely, because they are often a significant source of financial support for the family, and sometimes even its only source of income. For this reason, the elderly are unable to afford even basic social services or recreational services organized by the state (Luszczynska, 2021).

The construction of pension programs for the elderly population entails the setting of uniform public policy and is based on social laws that ensure the rights of aging. For this purpose, it is first necessary to understand the social requirements of the elderly themselves.

With concern for the elderly in society, it is necessary to refrain from a paternalistic approach on the political-social level, according to which society, and not the elderly themselves, know what is good for them. It is necessary to bring the topic to public discourse in which all the social groups participate and the voice of the elderly will be heard. The elimination of a paternalistic attitude towards the elderly at all social levels is possible when the independence of the elderly in society is maximized, their autonomy is cultivated, they are treated with respect, security is created for them, and their self-respect is promoted. The situation of the elderly in society in relation to other age groups necessitates that modern Western society change the policy and culture that exist regarding the elderly, through the creation of an environment of welfare devoid of discrimination according to age. This change should begin with a change of attitudes among the makers of policy in society (Itula-Abumere, 2012). Social segmentation into different groups based on age, social-cultural status, origin and race creates a methodical and consistent harm to weak social groups. Modern Western society that absorbs migration and becomes a multicultural society is supposed to create a shared culture for all with one system of norms and values uniform for all. For the creation of a healthy coexistence of a variety of social groups, a society is supposed to create an atmosphere of mutual support, trust, belonging and continuity. When this does not happen in actuality and different social groups hold their values and these values are fundamentally different from the values of a joint society, great social gaps are created. The gaps that cannot be bridged prevent the co-existence of these groups and conflict between them is only a matter of time. When the intercultural difference is too large, the factor that binds is harmed and social verbal, and physical violence increases against minorities as a tool for persuasion and coercion for the achievement of conformity (Napier, et al., 2014).

In the previous century, Max Weber attempted to explain inequality between different social groups through the opportunities given to the individual in his life. He maintained that inequality between groups is born from the difference in the opportunities to obtain goods for the achievement of satisfaction and quality of life at a high level. Therefore, in reality, the individual’s ability to achieve opportunities to obtain goods, of any type, depends on the individual’s belonging to a social economic status and on his health, education, gender, race and nationality (Weber, 1978). In other words, people are not born equal in terms of the opportunities that society places at their disposal. Modern Western society, with age, as individuals age, places at his disposal fewer and fewer social opportunities (Korkmaz Yaylagul & Seedsman, 2012).

Today, in comparison to the population of the elderly in modern Eastern society, the population of the elderly in Western society is healthier, with a significantly longer life span, in light of the relatively good access to medical services and availability as needed of quality care. However, the rise in the life span, the rise in migration to Western society, the movement of young people to the cities, and the leaving of elderly parents alone, without supervision and assistance, have led to the creation of a crisis of care of the elderly in modern society. The constant reduction of resources further deepens the crisis of the care of the elderly. Many countries in the Western world, already today, have considerable difficulty in providing a solution to the needs of the local elderly population that steadily is aging. In other words, as the population ages more, the social networks that are supposed to instill social safety and appropriate care in old age steadily diminish, until in the future they may completely disappear without intervention. Furthermore, in parallel to the crisis of the care of the elderly, a crisis of the working population arises. And, it is socially expected that children will take the care of their elderly parents upon themselves. Thus, the lack of dignity of the elderly, the constant harm to their basic rights, force society to think about the question of what the role of the elderly person in contemporary society is. The society of our time is beginning to search for an appropriate response to this question (Sherif Trask, 2010).

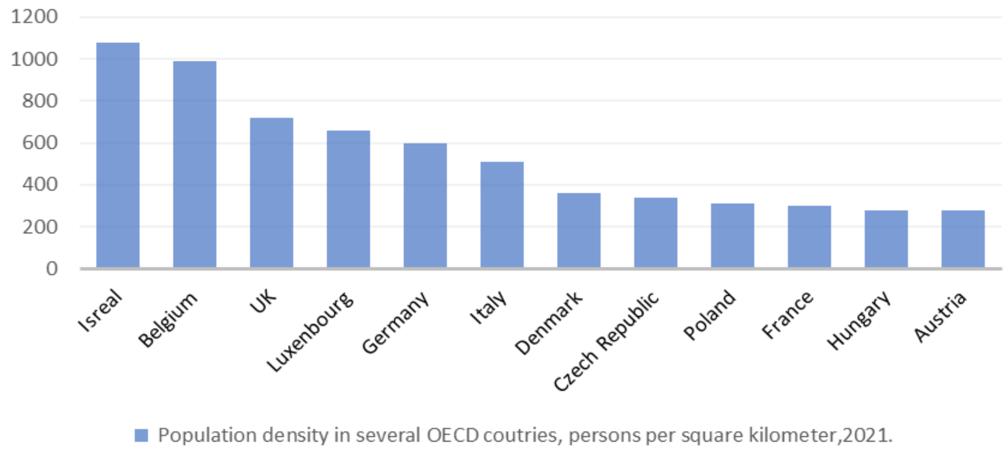
An objective analysis of the aging situation raises a very well-established danger in modern society - that the elderly are useless to society. This widespread and entrenched belief not only is a central feature of reality but is also the most destructive factor, as it derives its power from the beliefs of the elderly themselves (Thorsteinsdottir, et al., 2015).

According to Korkmaz Yaylagul and Seedsman (2012), it is necessary to see in the elderly not only a diverse group but also a new social group that constitutes a new workforce and a social resource that has not been recognized until now. Moreover, this group that is created, the elderly, which is steadily increasing, is not only one of the results of globalization that influences the new face of society but also a new spirit that will completely change the reality familiar until now. Also, the humiliating stereotypes regarding the elderly who were accepted until today no longer benefit society, and it is necessary to perform work for a change in the perception of aging in society.

4.2. A general description of the population in Israel.

Israel is a small country both in terms of its territory, spanning only 21,501 square kilometers, and its population, which has grown to over 9.7 million inhabitants as of 2023. By comparison, Israel was home to about 780,000 residents at its establishment, at May 15 1948. In light of this indication, it is important to note that Israel leads in terms of population density compared to selected OECD countries (Central Bureau of Statistics, 2024).

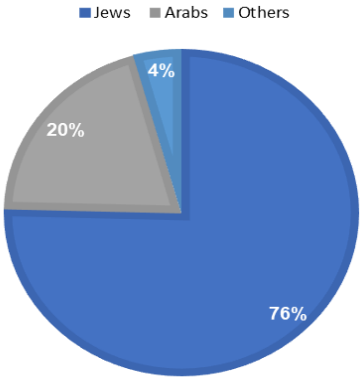
Figure 3: Population density in several OECD countries persons per square.



(Central Bureau of Statistics, 2024; Eurostat, 2024)

As of 2023, approximately 72.6% of Israel's population are recognized as Jews, totaling around 7.1 million. Additionally, about 21% are Arab-Muslims, Arab-Christians, or Druze (approximately 2.037 million), while roughly 6% (about 534,000) fall under the category of others, including 300,000 Jews classified as having no religious affiliation under the Law of Return. The remaining individuals in this category encompass non-Christians and members of various other religions and nationalities (Central Bureau of Statistics, 2024).

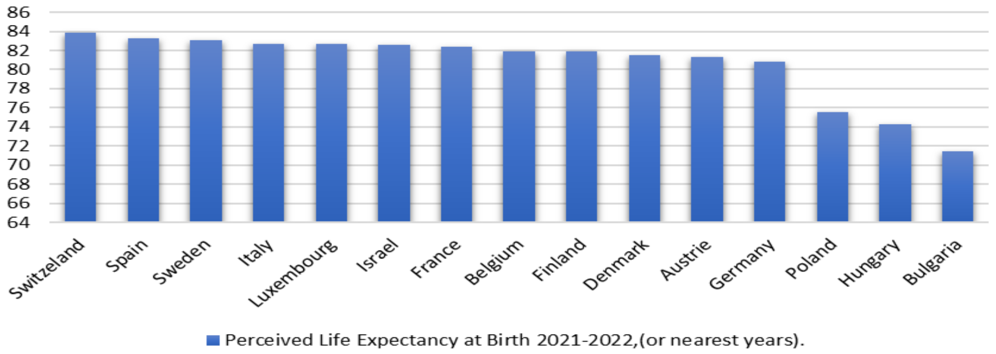
Figure 4: General population in Israel.



(Central Bureau of Statistics, 2024)

The average life expectancy in Israel stands at 83.5 years as of 2022, placing it fifth globally. Israel boasts the fastest population growth rate compared to other developed nations, with a 2% growth rate among the Arab population and 2.1% among the Jewish and "other" populations. It is projected that by 2040, Israel will become the most densely populated country in the OECD (Central Bureau of Statistics, 2024; Eurostat, 2024).

Figure 5: Perceived Life Expectancy at Birth 2021-2022, (or nearest years).



In 2023, approximately 63,000 individuals were added to Israel's population through immigration, with around 59,000 new immigrants. Notably, about 40% of Israel's Jewish population consists of new immigrants who have arrived since the country's establishment. These immigrants have originated from over 100 countries, with the former Soviet Union accounting for 60% (Central Bureau of Statistics, 2024).

Israel's population is concentrated mainly in the central area along the coastal plain, with smaller populations in the north and south. The country's demographic makeup is diverse, encompassing Jews, Arabs, Druze, Circassians, Bedouins, religious and secular individuals, senior citizens, new immigrants, and individuals from various Jewish backgrounds (Central Bureau of Statistics, 2024).

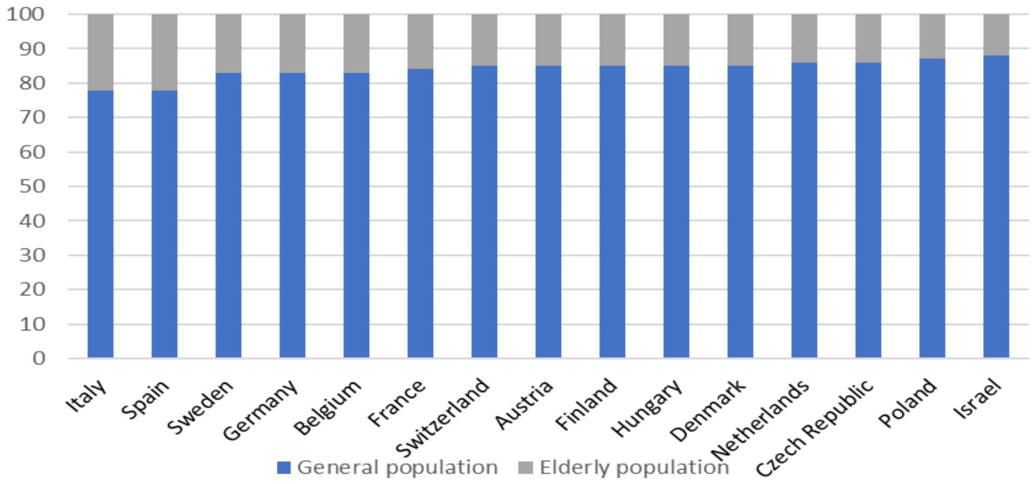
The age-standardized mortality rate in Israel experienced a decline until the onset of the COVID-19 pandemic in 2020. Subsequently, there was an increase in the death rate due to the pandemic. Notably, cancer has been the leading cause of death since the late 1990s, followed by heart disease. There has also been a shift in causes of death, with dementia becoming a significant cause for women in recent years (Central Bureau of Statistics, 2024).

Two major events expected to impact Israel's population are ongoing legal reforms within the ruling coalition parties and the October 7 war, triggered by incidents surrounding Gaza. The full extent of these effects remains unclear.

4.3. A general description of the elderly population in Israel, compared to OECD countries.

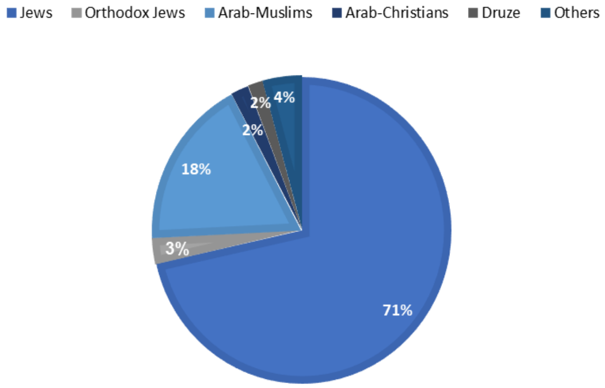
About 998,000 elderly people live in Israel, which is 11.4% of the country's population. This percentage is significantly lower than the average among the OECD countries.

Figure 6: The proportion of the elderly in Israel and selected OECD countries, to the general population, 2023.



It should be noted that the elderly population in Israel, compared to OECD countries, is very diverse. The difference is especially noticeable on a national and religious basis.

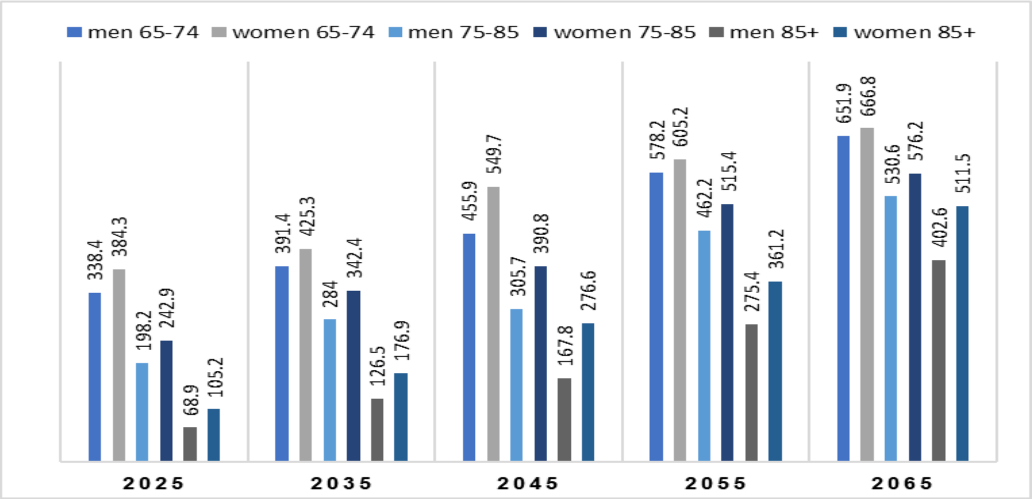
Figure 7: Elderly population in Israel, by nationality and religion.



At the end of 2021, close to 41% of seniors were 75 years old or older, and 11.8% of them were 85 years old or older. The total population will continue to increase in the coming years. According to the forecasts, up to the year 2040 the number of people aged 65 and over in Israel will be about 2 million. The percentage of the elderly in the population will be 14.2%; The number of those aged 75 and over will be 1,065,200.

The number of people aged 85 and over will be approximately 400,000 - in 2065, the proportion of senior citizens is expected to increase to 15.3% (Central Bureau of Statistics, 2024).

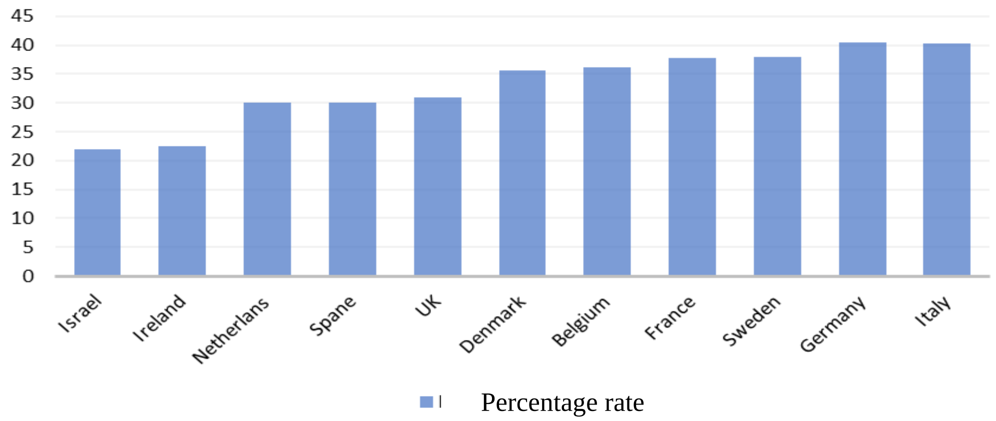
Figure 8: Population aging forecast in Israel, between the years 2025-2065, by gender per 100,000.



Furthermore, the percentage of elderly people in Israel varies among the different populations that make it up, with the elderly from the Arab sector making up only 4.9% of all the elderly in Israel, and the ultra-Orthodox elderly making up 2.7% (Central Bureau of Statistics, 2024).

In addition, the percentage rate of elderly people in Israel is also one of the lowest among the OECD countries and the rate of increase in the percentage rate is relatively moderate. However, it is important to point out that the aging of the population in Israel is mainly concentrated among the non-Orthodox Jewish sector, which has the highest employment rates. Hence, while the percentage rate of elderly people is low in Israel, examining the increase in the percentage rate of elderly people among the most productive sectors of the economy shows a trend similar to what is happening in all OECD countries (Central Bureau of Statistics, 2024; Eurostat, 2024).

Figure 9: The percentage rate: number of people age 65+ in Israel and selected EU countries, 2022.



The income of the elderly in Israel consists of public pension income, namely the old age pension from National Insurance, private pension income and salary from work. The scope of the public pension in Israel is one of the lowest in the OECD countries and this income constitutes only about 30% of the total income of the elderly (Central Bureau of Statistics, 2024).

For the scope of public spending on old-age pensions in Israel to match the OECD average according to the country's percentage rate, old-age pensions must be increased by 20.4%, which, according to the National Insurance budget for 2018, is about NIS 5.6 billion (Israel in Figures Selected Data From the Statistical Abstract of Israel, 2022).

Against the background of the low investment in old-age pensions, the percentage of employed elderly people in Israel is one of the highest in the OECD countries and stands at over 20% - however, among the Arab population, the proportion of employed elderly is only 6.1% (Israel in Figures Selected Data From the Statistical Abstract of Israel, 2022).

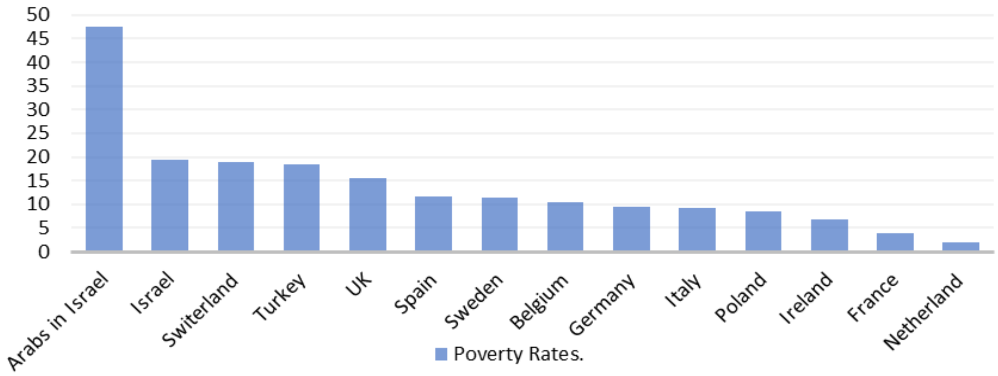
The number of people insured with a private pension in Israel has been on a constant upward trend since the holding of a pension fund became mandatory in 2008. As of 2014, 70% of Israeli citizens held a pension fund compared to 37% before the reform.

As for the poverty rate among the elderly in Israel, after transfer payments about 17.7% are defined as poor, a figure that is only slightly lower than the country with the highest rate of poor elderly, the USA, with 17.8%.

As a reflection of this, the percentage of poor elderly in Israel before transfer payments was, as of year 2015 , the lowest among the OECD countries and was about 42% - hence the system of budgetary transfers for the elderly in Israel is neither progressive enough nor effective in helping the weakest elderly in society (Israel in Figures Selected Data From the Statistical Abstract of Israel, 2022).

The poverty rate among Arab seniors in Israel was, as of 2016, 57.5% of all seniors in the sector. The income disparity between Arab elderly and Jewish elderly is reflected in all sources of income with an emphasis on private pension income, whereas as of 2014 - only 16% of Arab elderly people benefited from private pension income (Central Bureau of Statistics, 2024; Eurostat, 2024).

Figure 10: Poverty rates among elderly in Israel and OECD countries, 2020.



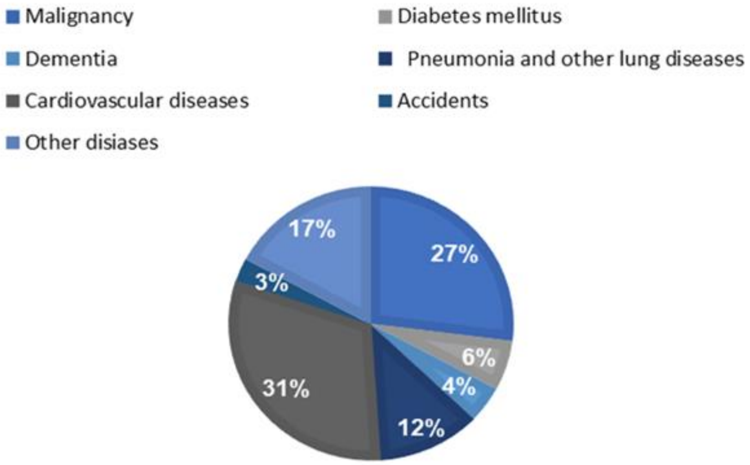
4.4. Main demographic findings: health characteristics of the elderly in Israel:

Life expectancy at birth reached 84.8 years for women and 80.7 years in 2020 for men. The life expectancy of Jews and others is higher than that of Arabs: in 2020 the gap between the population groups was 4.8 years for men and 3.8 years for women. Life expectancy at age 65 in 2016-2020 is 21.9. The life expectancy at age 65 of Jews is higher than that of Arabs (Central Bureau of Statistics, 2024).

In 2019, the age-standardized death rate per 1,000 +65 was 40 for men and 31 for women. Arabs had a higher rate compared to Jews: 49 for men and 41 for women.

60.8% of those over 65 died in a hospital in 2020, a rate slightly lower than that among those aged 64-0 62.6%. The main cause of death, both among those over 65 and in the general population, is malignant tumors. Among 65+-year-olds, other main causes are heart disease, dementia, diabetes, infectious diseases and cerebrovascular diseases.

Figure 11: Causes of death in hospitalization among the elderly, 65+ in Israel.



In 2019, 37,794 people over the age of 65 died, which is 82.2% of all people who died in Israel this year. The share of 65–74-year-olds in the total number of deaths is 21.0%. The share of 75–84-year-olds in the total number of deaths is 31.6% and the share of 85+ year-olds in the total mortality figure is 47.4%. With increasing age, the relative share of heart diseases, blood pressure and vascular diseases, hypertension, acute myocardial infarction, other ischemic heart diseases, other heart diseases, diseases of blood vessels in the brain, arteriosclerosis and other diseases involving blood circulation all increase (in the causes of death: from 18.6% among 65-74-year-olds to 28.1% among age + 85). The relative share of malignant tumors decreases with increasing age from 37.9% among the 74-65-year-olds to 15.1% among the 85+-year-olds. The relative share of dementia among the causes of death is 5.8% among people aged 65+ and increases with age (Central Bureau of Statistics, 2024).

4.5. Medical care for the elderly: necessary versus acceptable.

Quality care of the elderly population is a global responsibility and an interest shared by all decision-makers in modern society. Aging is a natural life process made possible by economic, social and medical development in the world and it constitutes a right received by the aging population today. The lifespan at the age of 65 in modern Western society reaches 85-90 years. Today, in comparison to the past, because of the rapid development of medicine, many chronic diseases, such as cardiovascular disease and kidney disease, do not constitute a barrier to a long life and a good quality of life (Smebye, et al., 2016).

However, the population's aging brings problems that society had not necessarily recognized previously, and many of them fall into the field of medicine and health. The aging process causes a rise in the percentage of the elderly in the population and consequently the appearance of a range of new illnesses that involve additional systems in the human body. These illnesses require medical follow-up, different treatments, and daily support of the patient. In addition, care and follow-up among the elderly entail taking into account the factor of body frailty during old age, in addition to the appearance of chronic illnesses related to a long life (Soreide & F Desserud, 2015). Thus, many hospitals face the complex challenge of coping with the treatment of the elderly population. In parallel to the physiological situation of frailty because of advanced age, this is a population characterized by clinical instability and a high risk of deterioration in their cognitive situation, especially hospitalization. Even if the reason for the hospitalization is not related to the worsening of chronic illnesses (such as pneumonia, influenza, etc.), it may constitute a trigger for the disruption of the balance in health and the worsening of the elderly person’s situation. In addition, hospitalizations in old age are steadily more expensive in comparison to the young population that receives medical services in hospitals. Furthermore, every invasive or noninvasive intervention for the assessment or treatment of illnesses or medical situations harms the individual’s autonomy and functioning and may bring about dependence after hospitalization. In the case of the care of the elderly patient, a functional limitation after hospitalization for the most part is irreversible. In other words, the hospitalization of the elderly is far more complicated and longer and entails multiple implications for the elderly person’s life and health. A clear relationship was further found between treatment successes in hospitalization and the presence of chronic morbidity, especially in the elderly population. The multiplicity of chronic illness harms the chances of treatment success during hospitalization and raises the risk of the development of dependence in the performance of everyday activities (Mercante, et al., 2014).

As of today, most Western countries cannot provide data regarding common chronic illnesses and the treatments entailed by them in the elderly population. Therefore, the treatment outcomes may not only be unexpected but also surprising in a bad way. In addition, the early identification and prevention of the deterioration of illness into situations of medical emergency among the elderly save both systemic and private costs, through the prevention of the performance of emergency treatments, a large number of which are invasive, with their success entailing physical reserves (Soreide & F Desserud, 2015).

Topaz (2009) identifies geriatric care as a significant weakness within the contemporary healthcare system. Elderly patients may be treated for one or more diseases, but there is a lack of medical treatment that takes into account the specificity of this period of human life and refers to the elderly person as a collection of diseases and not as a whole person. Today, the systemic care of the elderly not only is far from holistic but is also characterized by a serious lack of resources, such as geriatric doctors and geriatric beds. The lack of understanding of the uniqueness of care for the elderly harms society’s ability to effectively deal with the phenomenon of aging (Topaz, 2009).

To successfully cope with the phenomenon of aging, a modern Western society must internalize that the group of elderly people is not similar to other social groups. This is a group that requires unique medical support that cannot be compared with other social groups. The research of diseases and physiological situations that accompany the process of aging and the care of the elderly is called geriatrics. It is an area that belongs to the field of medicine and constitutes a subfield of family medicine and internal medicine. Geriatrics, because of its engagement in the special needs of elderly people, is different from other areas of medicine. The body of the old person is physiologically different from the body of the adult, since during the aging process the functioning of the systems of the human body begins to decline, thus causing the development of different diseases. The rate of decline in the functioning of the systems and the appearance of chronic diseases depend on the previous lifestyle during every person's life. Consequently, old people develop many chronic illnesses and develop general functional decline rapidly relative to young people. In addition, an elderly person develops difficulty in understanding what occurs around him and loses the ability to follow the instructions of the caregiving staff (Mercante, et al., 2014).

When speaking about the frailty of the elderly person's biological body, five parameters are addressed. These are a significant unintentional decline in body weight, fatigue in self-reporting, weakness (without another medical reason), walking at a slow pace, and poor levels of physical activity. This is the basis that must be taken into account when caring for the elderly in hospitalization even before beginning to build the treatment program for a severe problem with which the old person comes to the caregiver (Soreide & F Desserud, 2015). For most of the elderly, autonomy constitutes a necessary condition in care during hospitalization or at home and a secure basis for the quality of life regardless of the relationship to the multiplicity and complexity of chronic illness. Independence, continuity of residence in the elderly person's home, making important decisions in life (medical and other), preservation of the existing physical functioning – all these and other factors define the elderly person's autonomy in his life and his medical care and constitute a starting point in old age. Even when the elderly person moves from his home to live in an institution for seniors and continues to maintain his autonomy in life, his health is preserved at a good level for a longer time, despite a functional decline caused by ageing (Smebye, et al., 2016).

Because of the development of modern medicine, physicians who specialize in pulmonary diseases have succeeded in extending and improving the life of many pulmonary patients who in the past were fated to die in severe pain and with a short lifespan. Today, through medicinal treatments and invasive and noninvasive respiratory support, physicians succeed in significantly extending the lives of patients who have chronic lung diseases. However, an increase in the percentage of survival among chronic patients is not identified with satisfaction with the quality of life. As was the case in the past, today, chronic lung disease, because of its harm to breathing, entails a lack of quality of life and dependence on others. Still, despite all the medical means that exist, pulmonary diseases are characterized by a limitation in everyday activity that is accompanied by considerable discomfort (such as difficulty in breathing, a sense of strangulation, weakness and depression). Longevity, which today is achieved through medicinal and device-based treatments, no longer satisfies either the physicians or the patients. A modern medical viewpoint sets new treatment goals. When a patient and his family are found at the center of the treatment, longevity as a goal is no longer the top priority unless caregivers succeed in achieving a high quality of life and mental and physical well-being. This change in the treatment goals in modern medicine is especially prominent when speaking about the care of the elderly who suffer from chronic pulmonary diseases. It is agreed among physicians that the care of the elderly who suffer from respiratory diseases is palliative and constitutes care for the rest of their lives. It is intended to preserve the current level of health through the prevention of factors that may bring about the outbreak of a chronic disease and to reduce the symptoms entailed by lung disease, such as weakness, shortness of breath and depression. Moreover, treatments for the rest of life were meant to be determined by major guidelines for medical interventions at different degrees of invasiveness, for the continuation of the preservation of the individual’s autonomy until the day of his death, despite the chronic respiratory disease. Conversely, patients who have chronic respiratory disease in the terminal stages of the disease may demand more invasive treatments, even at the cost of additional harm to their quality of life, especially when the regular treatments no longer help as they did at the beginning of the illness (Scala, 2016).

In nephrology the situation is similar as medicine is influenced by social values. Western culture places at the top of its priorities the individual’s autonomy as a supreme social value. Accordingly, physicians guide the patients to make decisions that provide this value. Therefore, there are many cases in which a decision to begin dialysis is not a medical decision intended for the patient’s health benefit but an outcome of the individual’s personal, cultural and social values and those of his caregiver. In this situation, a large number of dialysis patients undergo the treatment following social expectations and pressure and not because of medical benefits or the patient’s desire. Consequently, the guidelines of the medical associations are influenced more by the values and expectations of society than by medical benefits.

This situation indirectly causes the medical misuse of dialysis (Ying, et al.., 2014). Nevertheless, for the setting of main interventions such as treatments for the end of life, it is necessary to adopt full cooperation in the making of the decisions that will exist as soon as possible with the determination of the assessment. It will be based on the severity of the disease and the patient's desires– and not his age (Scala, 2016).

In the field of cardiology as well, the situation is no different. The interests and desires of heart patients are not considered during the making of the decisions regarding the treatment or the management of chronic heart diseases, whether it is emergency or routine. Moreover, older cardiac patients report that they suffer from a lack of information regarding the possible treatments, medicines and lifestyle required for the patient in the shadow of the heart disease and define the communication with the caregivers as inadequate (Schroder, et al., 2015).

Moreover, often the patient's decisions and desires rely on the physician's prognosis, which is the outcome of a collection of statistical data. Therefore, it is possible that the physician's recommendation will not suit the patient in front of him. In addition, the decision regarding the timing of the use and the use itself of invasive interventions, such as mechanical ventilation, for respiratory support, is in the hands of the caregiver, who based the decision on clinical data, for the most part with the complete neglect of the patient's desire, especially in situations of medical emergency, such as the beginning of mechanical ventilation (Scala, 2016).

In dialysis also (treatment of terminal renal insufficiency) the decision from the beginning, especially regarding a situation of medical emergency, is found in the physician's hands and is not discussed at all with the patient and/or his family. It is important to note that this is a treatment that by nature entails considerable suffering, physical limitation and constant and significant harm to the patient's quality of life, and it is not at all important whether the patient is old or young; dialysis entails considerable suffering and difficult complications, such as infections, electrolyte disorder, etc. Therefore, a nephrologist does not need to provide care to the patient for whom from the beginning the benefit of the care is negligible and possible injury is not insignificant. When a nephrologist is convinced that dialysis will not bring benefit to the patient, even if the patient demands this, the physician is entitled to deny the patient the treatment. However, even if the physician is certain that the treatment of the chronic illness will bring more benefit than harm to the patient, the patient has the right to refuse the treatment, despite the anticipated benefits of the treatment (Germain, 2015).

Additional researchers support this opinion. In their opinion, dialysis as a treatment for renal insufficiency at the end of life is not for discussion, since this is an invasive treatment, entailing suffering, which does not promise reasonable health outcomes alongside the significant harm to the quality of life. Therefore, it is necessary to choose an alternative, such as, for example, peritoneal dialysis, which can ensure quality of life among the elderly who suffer from terminal kidney disease and constitutes a less invasive option that is more comfortable for the patient (Dousdampanis, et al., 2012).

The choice of a convenient treatment alternative is supposed to begin with an open discussion between the physician and the patient regarding the patient's preferences for the rest of their life. A research study conducted in Germany showed that most of the elderly (more than 90%) do not speak about their expectations regarding end-of-life treatment. In their visits to family doctors (general medicine), patients do not initiate conversations about death and treatments for the rest of life. Physicians in their meetings with their elderly patients and their family avoid conversations that may bring them to decisions regarding life and treatments before death. The great mental difficulty that is found in the conversation on topics concerning the rest of the life leads both the patients and the caregivers to erect a barrier that does not allow the tailoring of appropriate and holistic treatment for the elderly person. The treatment program built is a program that includes in it reference to chronic illnesses and care of them alone, without reference to the elderly person's mental needs and the physical frailty entailed by age. While caregivers themselves hold that the difficult topics are not discussed in the visit, they spare the elderly unnecessary pain in their treatment. In addition, even when topics regarding cardiac disease are discussed, physicians avoid speaking of the fact that heart failure is a terminal disease that may cause sudden death despite the medical care (Gerlich, et al., 2012).

The prevalence of chronic morbidity, the background of respiratory, cardiac and renal insufficiency, the decreased resistance of the immune system – all these, and additionally the decline in bodily functions entailed by age characterize the natural process of old age. However, today clear definitions of illness and care in old age are lacking. There is confusion between curative care, palliative care and end-of-life care. The situation becomes more complex, especially when decisions are made among the elderly (Dousdampanis, et al., 2012; Scala, 2016). The care of the elderly without exception is perceived as care at the end of life and leads to different treatment behavior, in comparison with younger adults. Thus, for example, the decision to convey the patient to the intensive care unit depends on the patient's age. In other words, the chances that an elderly person who is suffering from a worsening chronic respiratory illness will reach intensive care, in comparison to a young adult, are not high. Even when an elderly person has a better prognosis for a chronic respiratory illness, his chances of moving to the intensive care unit remain low because of his age (Scala, 2016). This situation is also similar with nephrology. Despite the opinion of many nephrologists about early dialysis achieving better medical results, the main consideration in the decision to offer this treatment to a patient is the patient's age. This fact is not surprising at all. A research study conducted in countries such as England, Italy and Australia, found that above the age of 75, the rate of kidney disease rises significantly. Thus, dialysis not only does not extend life while it harms the quality of life but also may harm and further damage the patient's basic health level. As the patient's age increases, the situation is more severe (Germain, 2015).

A research study conducted in the United States found that the rate of survival among patients above the age of 80 at the end of a year from the start of dialysis was about 54%, while the rate of mortality in the first three months from the start of dialysis was above 20%. Researchers maintain that a high rate of mortality derives primarily from the severity of renal insufficiency and additional mobility among the elderly who were included in the research study. It can be concluded that good treatment results of dialysis depend on the initial health background of the elderly person who is a candidate for dialysis and primarily on the patient's quality of vascular supply. Thus, for example, diabetes, atherosclerosis, and cardiac failure are common situations among the elderly population. They harm the supply of blood and constitute risk factors for dialysis failure and high mortality in the initial months after dialysis is started (Dousdampanis, et al., 2012).

In addition, there is no doubt that a treatment program before intervention should be mapped, especially when it comes to surgical treatments, since they have a greater risk of intervention. However, even when there is prior planning, it is not always possible to anticipate the elderly person's physiological responses after the operation. Chronic morbidity and natural physical frailty in old age, such as functional decline of the body's organs, emphasize the aspect of uncertainty relating to the treatment results in the surgery. The aspect of uncertainty becomes especially serious in medical emergency treatments, regardless of age. Emergency treatments do not enable treatment planning ahead of time. Caregivers also do not always have all the necessary information for the achievement of maximal care if talking about planned invasive therapy. Among the healthy elderly, it is always necessary to take into account the poor functioning of the body's organs following old age and the ease at which it is possible to disrupt the balance in chronic morbidity. Caregivers of the elderly are supposed to be ready for the expected developments in the treatment, despite the uncertainty that entails in the treatment of the elderly person. In other words, advanced age is itself a negative predictor, regardless of whether this is a routine or emergency, invasive or less invasive treatment. Emergency treatments save lives and as such are defined as more aggressive. However, emergency treatments such as urgent operations, regardless of their level of aggressiveness, among the elderly may cause more harm than benefit. Therefore, the biological changes and the physical weakness and frailty related to age cause caregivers to weigh each case separately. Thus, in the future, skilled and professional caregivers are expected to care for the elderly as a separate population and not as a part of the general group of adults (Soreide & F Desserud, 2015). It is not at all surprising that society refers to the elderly only as unnecessarily sick people who burden others with their maintenance costs. In Topaz’s opinion, this enables the development of ageism (Topaz, 2009).

According to Germain (2015), it is not ageism to not offer dialysis as a treatment for elderly patients who have renal insufficiency. The reverse is true; it is for the good of the patient, whose age plays an important part in the considerations to offer treatments against chronic disease. Elderly patients who suffer from terminal renal insufficiency have a short lifespan, and therefore the nephrologist’s role, first and foremost, is to prevent the unnecessary suffering of the patient or at least to reduce it to the greatest possible extent in the end-of-life, especially when the patient is elderly. According to other researchers, the elderly who suffer from terminal renal insufficiency constitute a socioeconomic problem that will become in the future even more complex. They maintain that the early identification of the illness and adjustment of the treatment at the right time may improve the patient’s prognosis and reduce the socio-economic implications entailed by the disease. In their opinion, there must be a balance between the assessment of the disease and the treatment that should be offered for this illness according to the levels of severity. In other words, as with any other chronic illness, under-diagnosis and over-diagnosis are equally detrimental and will require of the health system in Western society future additional costs that are expected to be higher than usual (Dousdampanis, et al., 2012).

The source of discrimination and inequality in health that is expressed in the diagnosis of the illness and the treatments suggested for patients and family members derive from social-cultural values and expectations. According to Schroder et al. (2015), the main basis for inequality between patients in health is their socioeconomic status in society. In addition, age merely exacerbates the existing discrimination but does not constitute a source of the problems. For instance, research studies conducted in England, Germany and Holland show similar results. According to these results, the rate of mortality among cardiac patients on a low socioeconomic level is higher than the rate of mortality among cardiac patients of a higher socioeconomic level. As the age of the cardiac patients increases, the mortality rates increase at all socioeconomic levels. However, the rate of mortality among adults of a low socioeconomic status indicates a sharper increase in comparison to that of a high socioeconomic level. A close look at the problem shows that patients who are painstakingly monitored by a cardiologist and remain in a longer period in cardiac rehabilitation are more educated and better off patients. In addition, more than 76% of cardiac patients who come from socio-economically well-off backgrounds undergo expensive invasive interventions for the renewal of blood flow to the heart. It is known that intervention for blood flow is an activity whose benefit is high when it is as close as possible to a cardiac incident. Therefore, if a patient has money and the possibility of rapidly coming to an emergency cardiac medicine institution, he has a higher chance of receiving intervention for the renewal of the blood flow to the heart. In contrast, a cardiac patient without financial means does not come in a suitable window of time for invasive intervention for the renewal of the blood flow to the heart and cannot achieve cardiac rehabilitation after a heart attack. In other words, cardiac patients who belong to a low socio-economic class not only suffer from a heavy health burden and deficient health results but also have less good and less consistent cardiac treatment (Schroder, et al., 2015).

Another research study in the field of cardiology presented discouraging data. About 2-5% of people aged 65-75 will develop heart failure and more than 10% of those above the age of 75. The data are worrisome since at an advanced stage of the disease the patients suffer from severe physical and mental symptoms, including difficulty breathing, extreme tiredness, chronic pain, anxieties, dependence, social isolation and closedness. Most of the symptoms of heart disease not only cause frequent, multiple and lengthy hospitalizations but also shorten the elderly person's life span (Gerlich, et al., 2012).

With the health deterioration caused by chronic respiratory diseases, regardless of the patient's age, on balance, there are two treatment choices: mechanical ventilation and non-invasive ventilation. Non-invasive ventilation is a treatment choice in many medical situations, such as COPD (Chronic Obstructive Pulmonary Disease), pulmonary edema, hypo-ventilation following obesity, and deformation of the chest. This type of artificial respiration has many health advantages and entails fewer fatal complications in comparison to mechanical ventilation. Sometimes non-invasive ventilation does not supply over time the patient’s respiratory needs, and then there is the need for artificial ventilation that entails intubation (the insertion of a breathing tube into the lungs). In addition, non-invasive ventilation, in comparison to mechanical ventilation, lessens the quality of life, although it does limit the freedom of physical movement to nearly the same extent. Among the elderly, it is the preferred possibility. There are many reasons for this. The main reason is that non-invasive ventilation harms the quality of life to a lesser extent. This is a critical consideration in a population such as the elderly, who are defined as a population at the end of life (Scala, 2016).

Nephrologists also cope with a similar dilemma when they care for the elderly population with chronic diseases in the kidney and urinary systems. What should be done when it is necessary to shift to more invasive means for the treatment of chronic illnesses? First, no harm must be done. In their opinion, for all physicians, without differences in their specialization, a main consideration in the choice of the treatment for the patient following chronic disease is the benefit versus the harm that the treatment may bring with it. It is important to note that even if one chronic illness is present, such as kidney insufficiency, as the patient’s age increases, his situation is more prone to trouble than that of a young patient. Also, the treatment possibilities that can be offered to him in situations of the worsening of the chronic illness are steadily and sharply reduced. In other words, as the care of the chronic illness becomes more invasive and requires many more visits to medical institutions, they entail greater suffering. When the treatment of the outbreak of a chronic illness is provided to a patient of an advanced age the benefits of the treatment are lessened and the chance of possible harm increases (Germain, 2015).

The worsening of the chronic illnesses and deterioration in the situation of the elderly patient cause his caregivers to adopt emergency treatments, some aggressive in nature, which may be less beneficial at the end of the intervention. In addition, a prognosis of intervention that is based on chronic morbidity among the elderly population for the most part leads to undesired outcomes. In other words, an elderly patient who is sick with chronic heart, lung, and/or kidney disease can deal with the surgical intervention itself but may not withstand the possible post-intervention complications. However, research studies indicate that more than one-half of the elderly population above the age of eighty who undergo urgent operations live an average of at least about three years. This time would not exist if the urgent surgical intervention had not been performed. While among patients above the age of eighty following urgent operations, there is an increase in the death rate and the hospitalizations become longer, the rate of the need for the intensive care unit increases, the functioning is harmed, and dependence on others is created in the performance of everyday activities (Soreide & F Desserud, 2015).

It is necessary to take into account that mortality rates rise as the patients' age rises. A research study that evaluated mortality as a result of emergency operations found that the rate of mortality as a result of emergency operations among adults is about 15.6%. Research conducted in Denmark showed a mortality rate of about 48% among the elderly above the age of 75. Among the elderly above the age of 90, the mortality rate doubles in comparison to younger patients. It is important to note that the mortality rate after surgical intervention is influenced by the invasiveness and urgency of the operation itself. As the patient's age increases, the mortality rate significantly increases in all categories (Soreide & F Desserud, 2015).

Germain (2015) proposes that nephrologists not initiate dialysis in elderly patients. However, if the elderly patient's health background enables this, it is necessary to decide at the beginning of the dialysis on cooperation between the nephrologists and the patient. According to other researchers, the decision of whether or not to offer the elderly patient dialysis is not at all as simple as it is presented. Therefore, in the offer of dialysis to the elderly patient, the caregiver must consider his desires, expected lifespan, quality of life and socioeconomic status (Dousdampanis, et al., 2012). Even in situations of emergency, when caregivers are limited in information and time to make decisions, caregivers are obligated to map the elderly patient's needs and interests with his family (Soreide & F Desserud, 2015).

The promotion of the desired results among the elderly in the surgical field is a complex task with decisive importance. It entails complicated clinical, health, and social implications on the health system. Today, there is no agreement among surgeons regarding the desired outcomes of surgical intervention and the correct level of aggressiveness in invasive treatments among the aging population. In addition, not every medical institution has the abilities and infrastructures needed for the performance of surgical interventions. There is considerable competition over the existing resources and as of today the allocation of resources in the health system, including in the emergency department, relies not only on the patient's medical needs but also on their age (Soreide & F Desserud, 2015; White, 2014).

Gerlich et al. (2012) maintain that it is not just invasive medicine which is deficient regarding the care of the elderly. Frequently, the elderly feel like a burden for their non-formal caregivers (such as spouses, family members and children). Discomfort related to having to be helped by relatives causes the shortening of visit times with a physician, the achievement of partial care of the elderly, and the failure to ask questions that bother the patient (Gerlich, et al., 2012). Hence, one of the most neglected topics is the care of sharp or chronic pain among the elderly. Most elderly patients suffer from pains at different levels and attribute this to their advanced age and do not seek help. Conversely, even when they do appeal to physicians, the pain is found in a low position on the order of care priorities and therefore is not addressed properly (Monroe, et al., 2012).

In parallel to the aging of the population and the constant rise in the number of elderly people, there is an increase in the number of the elderly with cognitive decline who need a guardian to make health decisions in general and regarding any medical care in particular. Cognitive decline at different levels of severity characterizes the elderly population in general. About 30% of them suffer from cognitive decline of a severe level (such as severe dementia) and continue to live in the community until they die. Despite their high percentage in the population of the elderly, their end-of-life care is essentially different from the care of the elderly who do not exhibit cognitive decline. For instance, work conducted in the United States found that old age institutions providing daily care spend about $11,461 (per month) less on an elderly person with cognitive decline in comparison to an elderly person whose mind is clear. The situation is similar when comparing the percentages of death in hospitalization. The elderly who suffer from dementia die 17.9% less during hospitalization, since they do not develop severe conditions for the medical service. In addition, the elderly who suffer from cognitive decline are moved during their hospitalization to intensive care units 9.4% less than the elderly who do not suffer from cognitive decline. These differences among the elderly between subgroups derive primarily from the objectives of the current policy, according to which care for the rest of life, when there is a known background of significant cognitive decline, must be less medically aggressive and more supportive and preventative (Nicolas, 2014).

In addition, according to the guidelines of the Renal Physician Association from 2010 it is necessary to avoid the start of dialysis among the elderly who suffer from severe dementia, especially if it is not possible to obtain the patient's cooperation during the therapy. According to researchers from Canada, factors such as the decline in the ability to communicate, the absence of the ability to understand complications entailed by dialysis, and the inability to make decisions independently – are absolute contraindications against beginning dialysis. An inability to decide on the commencement of invasive treatment whose benefits are doubtful projects the responsibility for the decision regarding the treatment onto a relative who is the guardian of the dementia patient, who also provides his care. An elderly person with dementia, because of his illness, cannot make complicated medical decisions. In the final stages of the disease, the patient is not able to express his opinion. Therefore, the decision to begin dialysis, as well as other invasive interventions, is in the hands of family – and guardians. Thus, the decision that is made in the family of the elderly person who suffers from dementia to begin dialysis relies on the sense of fear of family members that perhaps their decision to deny this or another treatment to the dementia patient will lead to his decline. Physicians who make care decisions for dementia patients are led by similar feelings. Caregivers are afraid of being blamed by family and by society that perhaps they did not do enough for the patient (Ying, et al., 2014).

In addition, not only are treatments of chronic illnesses among the elderly with cognitive decline unsatisfactory but also treatment of severe and chronic pain in this population is deficient, especially at the final stage of dementia. Dementia patients cannot express themselves, and the decisions of caregivers often rely on trial and error. According to many caregivers, if the evidence-based treatments in the field of pain alleviation among the elderly are not sufficient, then among dementia patients they do not exist at all. This finding is not at all surprising. Dementia patients are not included in the population of researchers not only in the field of pain but also in many other health fields, because of the difficulty entailed by the performance of research in a helpless population (Monroe, et al., 2012). The treatment of dementia patients entails many treatment challenges. One of the first ones is the preservation of autonomy despite dementia or any cognitive decline. The preservation of the patient’s dignity, with the integration of the elderly person into different decisions related to his life, enables the patient who suffers from cognitive decline to be placed at the treatment center and to be given daily care and medical treatment at a high level (Smebye, et al., 2016).

To enable the patient and his family members to be at the treatment center, there must be three necessary components. These are effective patient-caregiver communication, involvement in decision-making during care, and empowerment of the patient during the aging process and the appearance of the chronic disease. The duty of the caregiving staff within the framework of normal reciprocal relations is to legitimize the elderly person to express emotions in care, especially when difficulties in expression are identified. Thus, healthy coping with the process of aging and adjustment to physiological changes entailed by age is built. In the next stage, to make decisions within the treatment framework, both the caregiver and patient must crystallize a clear perspective regarding the care for the rest of the patient’s life. The caregiver’s role is to help the elderly patient form clear attitudes regarding his desires in the continuation, to help his family members and formal caregivers continue to uphold his values and beliefs in the continuation (Dousdampanis, et al., 2012; Pejner, et al., 2012). Hersch Nicholas (2014) agrees with this argument and emphasizes the importance of the advanced planning of care, especially for the elderly who suffer from cognitive decline. In her opinion, immediately after the diagnosis of cognitive decline, even at a low level, it is necessary to discuss with the patient and his family the continuation of treatment and interventions entailed by the disease in the future. This is a critical period for the patient, at which he can clarify his environment regarding his desires for the rest of his life. A minority of the elderly leave directives for family members regarding their treatment preferences if they suffer from cognitive decline. When a decision regarding the care remains in the hands of the formal caregiver or family member, it is possible that the goals in treatment will not be identical to those of the patient, if he could express them himself (Ying, et al., 2014).

Modern Western medicine has shifted from a paternalist approach (according to which the physician decides everything) to a participative approach (according to which a process of decision-making occurs in close cooperation between the caregiver and the patient). However, when speaking about the care of the elderly, especially dementia patients, the accepted approach has not changed and remains paternalistic. For example, according to a research study among elderly patients undergoing dialysis about 52% maintained that the beginning of the dialysis was the physician’s decision. Only 35% of the patients who participated in the research study felt that the medical decision to begin dialysis was based on their desire which was discussed with the physician beforehand (Ying, et al., 2014). A research study performed in the United States found that most of the elderly who began dialysis following a physician’s decision today regret it and feel that their decision to agree to begin dialysis was hastily decided under the physician’s pressure and without a suggestion of another alternative (such as, for example, to refuse to begin dialysis, with the consideration of treatment implications) (Thorsteinsdottir, et al., 2015).

Alongside medical treatments for coping with the implications of chronic diseases (such as dialysis and tracheotomy), there are natural processes of aging that require intervention. During aging, there is a decline in the energy intake that is expressed in the decline in the intake of the quantity or volume of food and calories. Some different explanations have been proposed for the natural phenomenon of the decline in the consumption of food, including a decline in physical activity (external energy consumption) and internal energy use required for the internal processes of digestion and absorption in the body. Healthy aging is a process in which there is a correlation between the decline in the intake and the decline in the use. However, in a significant percentage of the elderly, the decline in energy intake is greater than the decline in energy use, and therefore the result is weight loss. The decline in the consumption of food among the elderly has a psychological-behavioral, social and medical background along with a background of age-related physiological changes. All these factors disrupt the balance between intake and expenditure and cause the deterioration in the nutritional situation to the point of undernourishment. However, among the elderly who suffer from dementia, the development of eating problems is significantly frequent, in comparison to the problem in the general elderly population. Consequently, often caregivers adopt different means to improve or maintain the elderly person's nutritional status. Common means include a nasal tube and gastrostomy (PEG - Percutaneous endoscopic gastrostomy) when the gastrostomy tube is more common as the caregivers' choice among the elderly at the end of life. The insertion of a feeding tube (PEG) is intended to improve the consumption of food and liquids and to allow medicinal treatment for chronic illnesses. For instance, in the United States, the frequency of the elderly with cognitive decline who live in institutions is about 18%-34% of the total number of elderly patients. About 30% of these patients are elderly and suffer from dementia (Goldberg & Altman, 2014). PEG as a means of feeding is a widely used and preferred instrument for long-term use. Its popularity was acquired because of its advantages, which exceed the possible complications deriving from its insertion and/or use among the population of oncological patients, muscular dystrophy patients, and post - CVA rehabilitation patients. While its disadvantages following complications in the insertion and/or use in the elderly population in general and in the population of dementia patients, in particular, are not sufficiently clear, these do not often exceed its advantages in treatment. Although the insertion of a feeding tube (PEG) among the elderly and especially among dementia patients does not prolong survival, does not improve the elderly person's nutritional status, and increases mortality connected with its insertion, in recent years the percentage of patients being given feeding tubes has been constantly and consistently rising (Mendiratta, et al., 2014). Among elderly patients with dementia, mortality following PEG insertion ranges from 13% to 54%, and at the end of the first year after the insertion the percentage increases and ranges from 78% to 84%. Mortality among the elderly after the insertion of a feeding tube is significantly higher than among other patients. In addition, the survivability after the insertion of a feeding tube among the elderly with dementia is only about 195 days. This finding is significantly low, in comparison to survivability among other groups using such tubes (Goldberg & Altman, 2014). For the most part, the decisions of physicians to insert a tube among the elderly are not evidence-based because of the lack of research studies that provide true and full data among the elderly. When the physicians decide to insert a tube, for instance, in oncological patients, they rely on the prolonging of the patient's life, the improvement of the patient's quality of life, the reduction of risk that the stomach contents will reach the lungs, the promotion of physical wellbeing, and the improvement of nutritional status. However, among the elderly, and especially among the elderly with dementia, the insertion of a tube does not achieve similar treatment benefits. The fact that the physicians who decide to insert a tube in the elderly population ignore these data and have considerations that are not relevant in the making of the decision to insert increases the potential for abuse. This harms the treatment outcomes (Mendiratta, et al., 2014). However, the aging of the population and the rise in the elderly who need help raise the need for additional skilled and professional caregivers. The insertion of an internal feeding tube enables more comfortable treatment for the caregiver, allowing one caregiver to provide service concurrently to many patients (Goldberg & Altman, 2014).

Emotional support constitutes a necessary basis for medical treatment, especially when referring to treatment for the rest of life in general and among the elderly in particular. The emotional component in daily care not only improves the subjective assessment of health but also improves the clinical outcomes. For instance, surgery for hip joint repair involves many limitations and painstaking discipline on the patient's part. When a caregiver succeeds in providing care after surgery for hip joint repair in an emotional manner, the risk of the development of depression among the elderly who undergo the surgery is reduced significantly. The period of rehabilitation of the elderly person is shortened, through the presentation of better clinical results. However, the elderly need a caring and understanding emotional environment and caregiver, not only in times of sickness. In everyday life, when there is a loving environment that is emotional and pleasant, the elderly adjust better to different situations related to aging and the appearance of chronic illnesses and even cope with them more effectively and easily. In contrast, when the individual ages in an indifferent environment or social isolation, he will tend to evaluate his health as less good and will fall sick more frequently (Pejner, et al., 2012). The building of a good communicational culture between the caregiver and the elderly patient and his family enables the care to be enriched with emotional and social support and more holistic, more dignified, and more comfortable care is provided (Gerlich, et al., 2012).

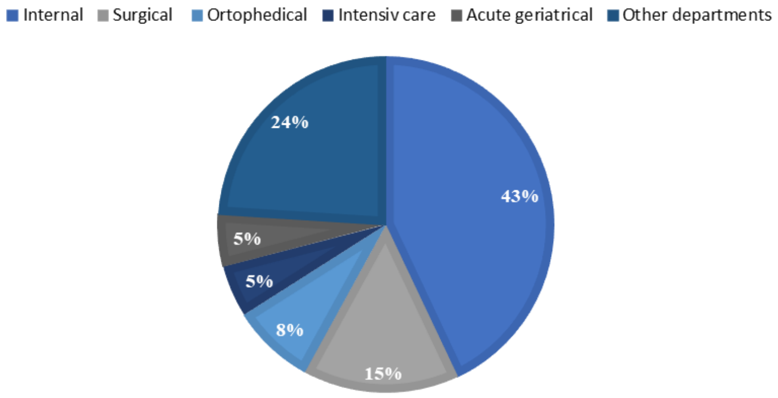
The professional obligation of nurses is to provide for the patient a solution to his emotional, physical, social, mental, cultural and spiritual needs during medical treatment. However, in actuality, the creation of a pleasant and sensitive treatment environment is not easy. It necessitates considerable emotional and professional investment on the part of the nurses who work in the institution. The nursing staff describes daily work as stressful and difficult. It requires the simultaneous management of many professional tasks that must be performed with great precision and at regulated times. Therefore, the creation of an effective atmosphere, for a high level of medical care, is not always possible. In the opinion of nurses, medical treatment in a pleasant and sensitive atmosphere requires time, many skilled staff members, and a reduction of the task load. Hence, there are many situations in which nurses refrain from meeting their patients' non-medical needs. Moreover, the caregiving staff often reports a lack of skill and knowledge for the supply of emotional care and the lack of personal efficacy in providing the patient with certain emotions, especially when talking about daily care for the rest of the life (Pejner, et al., 2012). It is easy, as a caregiver, to be task-oriented and limited to professional skills. However, to hide behind biomedical activity, without emotional involvement, is to perform the work superficially. For the elderly who suffer from severe cognitive decline, instrumental care without emotion does not yield good outcomes. Among the elderly with advanced dementia, the medical care at the end of their lives entails suffering and considerable pain. Therefore, a caring emotional and mental attitude in the medical intervention is more important than the intervention itself (Nicolas, 2014).

One of the additional challenges in the care is the achievement of social-cultural equality among patients, regardless of age, gender, race and nationality. The caregiver must be aware of social inequality so as to avoid it in the treatment framework. In other words, all caregivers should care for all on an equal basis, with awareness of differences between patients following the treatment requirements (Napier, et al., 2014). In the framework of the perception of equality as a supreme value, modern Western society defined healthcare as a basic right of man in society. Consequently, throughout history public policy developed for the financing of different medical services for the entire population. However, the aging of the population has led to a need to reconsider how the medical resources in society should be divided to achieve maximum benefit not only for the individual but also for society as a whole (Thorsteinsdottir, et al., 2015).

Western society raises many barriers on the way to carrying out the treatment. One of the most important barriers in society is age. In addition, certain illnesses, for instance, dementia, constitute another obstacle. The confusion between what is expected and what exists in actuality leads to the asking of moral-ethical questions. Should dialysis be avoided in the elderly when it is not possible to assess the quality of life expected in the future? Will the severity of the illness determine when the elderly patient objects to a certain medical treatment (Ying, et al., 2014)?

Conversely, equality with other patients does not always work in the favor of the elderly patient. Therefore, the performance of many medical treatments among elderly patients, such as dialysis, not only does not benefit the patient’s situation but is also physically and mentally detrimental. The multiplicity of ethical questions revolving around this issue and the lack of evidence examined in research for the making of optimal decisions even further emphasize the distress of the elderly population and their caregivers (Thorsteinsdottir, et al., 2015). In addition, the lack of adequate evidence-based clinical data, conditions of uncertainty in the care of the aging population, and lack of resources – all create among the caregiving staff a negative feeling regarding their ability to help the elderly in hospitalization and to reach better treatment results, despite advanced medical technologies. The moral distress that characterizes the caregivers of the elderly causes massive dropout rates from old age institutions and creates a deterrence against the care of the elderly (Mercante, et al., 2014).

Figure 12: Hospitalizations of the elderly (65+), by departments, in Israel, 2020.



4.5.1. Ethical dilemmas in treatment of the elderly.

The aging of the population in modern Western society challenges caregiving staff with many ethical issues, such as the allocation of medical resources, intergenerational justice, and issues of life and death (such as resuscitation and euthanasia). However, ethical issues in the care of the elderly population in reality are far more complicated, following negative attitudes towards the elderly in the general population. The health system is influenced by the social mood. Therefore, negative opinions are also prevalent among caregivers of the elderly, such as nurses. The elderly in modern society are perceived as a burden.

Caregivers of the elderly cope with the constant and consistent deterioration of the situation of the elderly population in the institution where they live until their last day. Thus, the care of the elderly requires a moral-ethical basis that preserves human rights in the care and shares responsibility in the care ('cure and care') between the elderly person, his family and the formal caregiver (Van der Dam, et al., 2012). However, in reality, a moral basis is not expressed. The care of the elderly is discriminatory and takes into account considerations that are not relevant to ethical medicine, such as the costs of medical treatment versus possible benefits. As expected, the elderly turn to medical services more than do young people, since they suffer from chronic illnesses more frequently than do young people. Consequently, the cost of the care of the elderly population is significantly higher than that of the younger people. Furthermore, a medical decision on the benefit of treatment among the elderly is not only misleading but also even dangerous. In reality, a medical decision based first and foremost on the benefit of the medical treatment is fated to create a discriminatory attitude against the elderly on the basis of age. For instance, medical care at a high cost for a limited number of young patients leads to greater benefit to society than do medical treatments for a large number of the elderly (White, 2014).

Moreover, according to many caregivers, the benefit of medical services, especially of emergency treatments, is less significant in the elderly population and may even bring about additional illness and increasing dependence on the health system (Soreide & F Desserud, 2015).

In light of the aging of the population, the demand for expensive medical services is steadily increasing. The increasing demand versus the lack of medical resources, the need for quality medicine on a high level for as many people as possible push the physicians in reality to base decisions upon many considerations, such as age, medical benefit, the physician’s morality and the patient’s desires, when ethical considerations are not at a high priority in decision-making. However, providing appropriate medical service, according to immediate medical demand, at the proper scope and time, not only increase the quality of the medicine among the elderly but also increase the treatment benefit for them and reduce unnecessary costs in care. Thus, quality medical care provided within the framework of the biological boundaries of the body’s ability ensures better health-treatment results. However, in actuality according to moral imperatives, the elderly receive low-quality medical care at a high cost with negative treatment outcomes. Hence, despite binding professional ethics, the patient’s age is a main consideration in the medical treatment. Therefore, medical treatment given to the elderly is found to be of a low level of quality, and as such it constitutes a social norm in modern Western society (White, 2014).

The use of gastrostomy among the elderly as a means of feeding is a controversial issue. On the one hand, its benefits among the elderly are not proven, and the complications it involves exceed its benefits. On the other hand, the rate of insertion in this population has been steadily increasing in recent years. In other words, a medical decision to begin internal feeding using a gastrostomy among the elderly is accompanied by considerations that are not related to the benefit of the elderly person himself, and therefore many ethical dilemmas arise regarding this matter (Mendiratta, et al., 2014). However, in consideration of the patient’s benefit, it is necessary to take into account the accessibility of the health system’s resources for some patients who need medical services. In other words, the individual’s benefit cannot exceed the general benefit, especially when referring to limited resources, such as medical services (Goldberg & Altman, 2014).

In addition, when caregivers consider beginning dialysis treatments, they see the goal of the extension of the lifespan, while upholding four main principles in treatment: respect for the patient’s autonomy, health benefits, prevention of harm from the treatment, and justice. However, when talking about the elderly population, caregivers are not always able to uphold moral principles. In other words, when the medical benefit is reduced to one goal, the extension of life, caregivers fail ahead of time in the treatment of the elderly population. Most elderly patients are not interested in the extension of their lifespan. Caregivers refuse to understand that sometimes the elderly have other, more important goals for end-of-life treatments – not the extension of life. Historically, technological progress in medical treatments has caused further extension in lifespans. However, every medical treatment, even the most advanced, has its limitations. The caregiver’s duty is to all the time update the patient and his family regarding the medical benefits and the possible harm, especially if the decision to commence or end the dialysis treatment is being considered. Evidence-based action does not support the performance of dialysis in the entire elderly population with renal insufficiency without exceptions. While from a moral perspective, a caregiver is obligated to make decisions at all times on the treatment continuum in cooperation with his patients, while presenting the required, full and trustworthy information (Thorsteinsdottir, et al., 2015). Moreover, the sole justification for the medical decision to use invasive treatment measures with possible complications such as death is the patient’s benefit and a significant improvement of his life. The rest of the considerations in the making of the decisions to use invasive medical means are supposed to be well researched as they have a high potential to be immoral regarding the population of the elderly (Mendiratta, et al., 2014).

At the basis of every medical decision, there are basic values of every patient in medical care - his right to autonomy, and his right to treatment that is given to him through the caregiver’s taking of responsibility. Informed consent on the part of the patient is intended to preserve the individual’s basic values in medical treatment and to provide him with the opportunity to make a decision independently. When a caregiver and patient agree on the medical care, the patient expresses his understanding and willingness for care and the caregiver brings with him his values, moral position and knowledge of professional ethics (Wandrowski, et al., 2012).

However, in reality, patients feel that they do not receive sufficient information to make a conscious decision at the beginning of medical care. A research study performed in the United States among elderly dialysis patients found that very few patients were satisfied with the content and quantity of information they received before the beginning of the dialysis and during it and felt that they relied on the physician and followed his decision (Thorsteinsdottir, et al., 2015). In modern Western society, informed consent has become something technical that is exploited by caregivers with the proper attention being devoted to its meaning. Informed consent is not only protection of the individual’s autonomy as a value that society worships but also the meticulous assessment of the patient’s desires, values, and preferences and respect for his decision, even if it is not identical to what is done in society (Thorsteinsdottir, et al., 2015).

Ethical issues that caregivers of the elderly deal with are different from general medical ethical issues, and they are found in the field of end-of-life care. End-of-life care of the elderly is supposed to be based on the quality of the communication with the patient more than on different medical interventions intended to extend the lifespan of the younger population. However, nurses who care for the elderly cope unendingly in the care with the dilemma between the elderly person's autonomy and benefit in care or autonomy and moral justice. Such situations are prone to problems, bring about conflicts in the care, and produce interpretations with a multiplicity of contradicting values. The solution to the moral conflicts that arise from the care of the elderly is supposed to bring about the greatest benefit for the patient and is always to be aimed at the patient's wellbeing. However, a research study performed in Holland found that caregivers in the making of ethical decisions knew well the patient's desire but were not able to act according to his demands. They also knew what morally was best to do but were not able to act in this way. During the treatment dissonance that was created, the caregivers felt an ethical crisis and thus suffered moral distress. This situation especially worsens when talking about the treatment of the elderly population. On the one hand, there are regular rules of care, a binding professional standard, and high social expectations from the caregivers. However, on the other hand, the opportunities for moral professional behavior according to these standards do not exist at all. Moral distress, which the caregiver feels, generally also characterizes the atmosphere in the organization where the treatment interaction occurs. The lack of openness and a work environment that prevents caregivers from maintaining sensitivity towards what happens causes them to adopt behavior that is subsumed into the mechanical routine and they lack an emotional attitude towards the patients and their peers in the workplace. When caregivers work under pressure and against their own moral beliefs, they feel frustration and create distance and suffer emotional alienation from their work with the elderly (van der Dam, et al., 2012).

Physicians who care for the elderly feel that the care or cessation of care at the end of life is based for the most part on the treatment prognosis and not on the patient's desires. According to many physicians, the existence of treatment instructions in medical situations is far more obligating than ethical considerations or the upholding of the patient's values, since the failure to uphold treatment directives may be interpreted as assistance in death or medical malpractice. Today, many physicians feel an absence of ethical tools in their ability to cope with issues at the end of life among the elderly. The absence of ethical tools, moral distress that derives from treatment decisions, binding professional values, and responsibility for the patient – all these and many other factors cause physicians to suffer a difficult ethical professional dilemma: to make decisions according to the existing directives or to go with the patient’s preferences and perform what is assigned to him morally. Lack of skill and ability to make ethical decisions at the end-of-life harm the quality of the care and the well-being of the elderly person in his final days and worsens the caregiver’s mental distress (Wandrowski, et al., 2012). The physicians’ mental distress in the care does not lead to a solution for the general situation that is created in a health system that addresses the aging population. Morally, it is urgently necessary to change the cultural and social indifference toward the elderly in general and towards their care in particular. The causing of a social change of this type is an essential part of the agenda of caregivers of the elderly and their social-professional duty (White, 2014).

Moral distress, which caregivers feel in their work, is a product of the cultural diversity created in the workplace with a multiplicity of caregivers and patients who come from different backgrounds. Care for elderly patients that occurs in old age institutions relies on teamwork. Every caregiver’s behavior derives from a different moral perspective that is influenced by the caregiver’s background. In addition, the family members of elderly patients who are found in institutions play a significant part in the burden of moral problems on caregivers in institutions. Often family members challenge caregivers through their involvement in a responsibility that does not fall within the field of formal care. Then, when the caregiver remains within professional boundaries and does not heed the requests of the elderly person’s family, the caregiver feels guilty and frustrated and sees his care as less emotional. It should be noted that every caregiver simultaneously sees to more than one elderly person and communicates in parallel with different families. Thus, many contradictions are created and they create tension. Caregivers feel that they bear the responsibility for the mental well-being of patients that is not protected in the care. In their work, daily, caregivers search for the balance between the desires of one patient and the preservation of the values of other patients in the institution. However, moral treatment of patients in old age institutions is treatment that integrates the elderly person’s life narrative (Van der Dam, et al., 2012).

This is also treatment that takes into consideration the values and preferences of the patient and his family. However, first and foremost, moral treatment is based on the caregivers’ values, their moral approach towards different issues in their work, and their ability to make care decisions solely on a moral-ethical basis even if the moral decision is not commensurate with the existing treatment instructions (Wandrowski, et al., 2012). Moral medical treatment in modern Western medicine is based on the physician’s moral/professional duty to provide care as a solution to the patient’s needs without influencing the elderly person’s ability to pay in return for the care (White, 2014).

In 1947, the Nuremberg Laws helped establish ethical laws for research studies on people. Participation in research is supposed to be voluntary. In 1964, the Declaration of Helsinki determined that research participants must be volunteers and they must receive all the necessary explanations relating to the significance of the research. Research participants give their informed consent. A decline in the individual’s cognitive ability prevents him from being able to fully understand the information about the experiment, the meaning of the research, and the implications of participation in it. In this situation, when an individual cannot give informed consent, family members or close friends need to be able to make decisions in his place but for his benefit (Monroe, et al., 2012).

Ethical principles enable the patient to receive equal treatment without appropriate conditions. However, this is not enough. Medical treatments are supposed to be divided justly according to the patient’s needs and desires (Ying, et al., 2014). In England, too, an elderly patient is permitted to agree or refuse to obtain medical treatment at any time and for any reason. During the process of making the decision on the treatment, the caregiver must ascertain that the patient has the cognitive ability to make decisions independently based on the full information provided by caregivers. By law, the patient has the cognitive ability to decide, unless the physician determines that he cannot do so. Therefore, an elderly person continues to be a patient in any type of medical treatment as long as he can make decisions independently. However, elderly patients are often found at risk of the development of cognitive decline due to a secondary situation of systematic infections, worsening of chronic illness, change in regular medications, use of opioids, hypothermia or pain. In this situation, when the patient does not have the ability to decide to receive or reject medical treatment, the caregiving physician makes decisions regarding the beginning of treatment by considering the patient's good (White, 2014). However, in actuality, the physician does not know better than the elderly patient what is good for him and does not clarify this with the patient and his family. Thus, a situation is created in which the patient agrees to dialysis since an option not to begin it was not offered to him. In other words, when in the treatment sessions there is an elderly person who can make his own decisions, it is hard for the physician not to offer him to begin dialysis following kidney insufficiency. However, a proposal that is based on the status of the elderly person's kidney disease is far from his values and goals at the end of his life. In addition, often the beginning of dialysis at an old age causes more harm than good to the elderly person and his family (Thorsteinsdottir, et al., 2015). Furthermore, as cognitive decline advances (as in dementia), the autonomy that appears as a basic right in life and the medical care of the elderly person may lead to neglect, isolation and lack of medical care. For many caregivers, respect for the elderly person's autonomy (even an elderly person with dementia) is to live the rest of his life with full overlap with his identity, with the preservation and concern for his health and existential needs (Smebye, et al., 2016).

However, in everyday treatment, caregivers cope with a difficult ethical dilemma. How is it possible to preserve the balance between the elderly person's autonomy at the end of his life and his safety and physical well-being? In reality, to overcome this, the care becomes paternalistic, guided by decisions, and sometimes in complete contradiction to the elderly person's interests and preferences. Many ethical dilemmas, such as this one, create considerable confusion and are not sufficiently discussed in the global literature. On the one hand, the caregiver must uphold the patient's rights in treatment and the values important to him, while on the other hand, the caregiver must respect the patient's autonomy, which is not always possible (Smebye, et al., 2016).

In modern Western society, there are many interpretations of personal autonomy, autonomy in medical care, morality, moral treatment and so on. However, the many meanings and interpretations given by caregivers to the same phenomena, and the lack of ethical clarity in medicine with social groups, such as the elderly create confusion and emotional distress among caregivers and harm the elderly found in treatment (Smebye, et al., 2016).

Morally and legally, the elderly are entitled to receive care of a level of quality equivalent to that of young patients. However, today, ethical medical care in the elderly population does not exist, following the lack of laws that create a strong basis for the creation of a social environment for this. According to White (2014), the legislation of appropriate laws and the enforcement of these laws in actuality may cause a change in the care of the elderly and overcome the indifference of Western society towards the elderly population and their medical care. In addition, it is necessary to raise a new generation of caregivers of the elderly who have social sensitivity and respect for the elderly and their care. A preliminary condition of moral change among caregivers of the elderly is the creation of appropriate conditions in society (White, 2014).

4.6. Culture as a basis for caregiving attitudes toward caregiving to the elderly.

Culture constitutes a basis for the individual's social life. The individual's thoughts, beliefs and behavior, from his day of birth to his day of death, pass through the filter of his culture and become a personal experience. In addition, culture places before the individual the rules, values, norms and expectations of society. Through them, the individual succeeds in existing as an integrative part of society. Culture enables the building of relationships between individuals in society and maintains their existence and cultivation, teaching the building of new relationships throughout the individual's life. It makes people in society special and gives them a system of shared symbols and interpretations for the decoding of events that occur in their environment. Culture creates social support, according to which the individual feels esteemed, sympathetic and protected when he acts as expected by other individuals. However, when there is a distance between friends, even cultures change and cause the creation of differences, which derive from changes in traditions, values, norms and beliefs. These cultural differences cause a different definition of the situation by people in similar social situations since the interpretation given to situations observed by people depends on the culture in which they were raised. In other words, language, symbols and customs influence the individual in his perception of the situation and in the interpretation of events that occur. Therefore, when people who are involved in any social event belong to different cultures, they may interpret the same situation differently. The awareness of the matter, as well as the lack of understanding, greatly influence reciprocal relations in a variety of social dimensions (Campos, 2015). Moreover, the system of values that the individual acquires in the process of socialization according to his belonging to a culture creates his social behavior. This behavior directly and indirectly influences his health over the course of his life (Napier et al., 2014). Sometimes these differences that are created on a multicultural basis are perceived as threatening, and therefore in mixed multicultural societies they may cause the hatred of foreigners. Lack of understanding, fear and hatred are often based on the absence of familiarity with a different culture and therefore contribute to the birth of detrimental stereotypes in society. There is no doubt that the ethnic diversity that exists today in modern Western society has added many social challenges. The multiculturalism that is created caused the formation of additional social gaps between different social groups (American Geriatrics Society Ethnogeriatrics Committee, 2016).

These gaps are especially prominent in health systems. With the global health system, there is a multiplicity of social groups with one shared requirement: to provide medical treatment on a high level of quality. Quality medicine and appropriate medical care for patients according to their needs and without discrimination are the moral bases required of caregivers (American Geriatrics Society Ethnogeriatrics Committee, 2016). While social gaps are a reality existing in modern Western society, the health system is nurtured by this reality. Following different types of lack of understanding of the basis of deficient communication between caregiver and patient, minorities tend more than the regular population to have a short lifespan, lack of access to medical services, and quality of life low relative to the general population of this age. Hence, the great challenge for both caregivers and patients from this cultural background is to build effective communication based on reciprocal trust and enabling closeness for the promotion of health (Cadoret & Garcia, 2014). According to Keshet and Popper-Giveon (2016), who researched health services in a multicultural society (Israel), the best answer to the improvement of the communication between caregivers and patients is the training of nurses in a multicultural workforce similar to the community of patients who daily consume the medical services in the country (Keshet & Popper-Givion, 2016).

It is important to understand that culture, in itself, is not positive or negative, even if it is fundamentally different from the culture of the majority of the population. The factors leading to the development of a lack of tolerance and inequality in society towards minorities, such as the enhancement of the difference between people and removal of the individual from the general population based on certain differences, are negative. In other words, culture itself is not harmful or beneficial but incorrect thinking and mistaken interpretations based on a system of values lead to friction between social groups. This situation may not only be detrimental and dangerous to the achievement of health goals but also harms the quality of care of the patient who needs care on a daily basis (Napier, et al., 2014). Cadoret and Garcia (2014) broaden this argument: they maintain that the patient can hold different beliefs and different health expectations from the session with the caregiver. Therefore, a caregiver does not correctly identify his true needs, interprets them from his cultural experience and based on his values, and thus harms the effectiveness of the communication between them. It is necessary to take into account that minority patients reach medical services in a complex health situation when there is already a further worsening of health and without adequate medicinal treatment. In addition, the gap in expectations between the caregiver and the patient from a multicultural background reduces trust in physicians and the health system among patients and causes the patients to make treatment decisions based on judgment, existing stereotypes and prejudices (Cadoret & Garcia, 2014).

It is possible to evaluate the influence of the local culture of the caregivers on the operations of the institution or organization according to the research findings of Geert

Hofstede. In his work, he examined the influence of the cultural factor on the patterns of management. Hofstede diagnosed that there is considerable cultural difference that is supposed to be taken into account for effective organization and management. According to his conclusions, following the research he conducted in IBM, international companies are managed according to the culture and social environment of the country in which they are geographically located, although they belong to one international organization. According to the collected data, Hofstede classified the cultural characteristics found in global organizations into five dimensions of culture (Hofstede, 2001).

The first of Hofstede's dimension is power distance. In this dimension, he addresses the degree to which society encourages and perpetuates the gaps in influence and division of wealth among its members. In his opinion, as the distance is greater, the gaps are more profound. This measure examines the relationship between superiors and subordinates. The second dimension speaks about individualism versus collectivism. This dimension addresses the degree of importance of personal interest versus group interest. Here Hofstede describes the individual's relationships with the group in a given society. When there are weak relationships, the situation is defined as individualism. As a result, the individual is expected to care for himself and his family by himself. In contrast, when a culture is defined as collectivism, it will be characterized by strong and cohesive groups with a high level of mutual concern. Hofstede examined this dimension by examining four main factors: time for personal and family life, good working conditions, occupational security and interest at work (Hofstede, 2001).

Another dimension that was classified by Hofstede is masculinity versus femininity. It reflects the degree to which the main values emphasize the stereotypical perceptions of masculinity, for example, competitiveness and assertiveness, as opposed to the emphasis given to stereotypical perceptions of femininity, such as sensitivity and concern for others. Thus, a "masculine" society emphasizes tangible achievement and outer impression. In contrast, a "feminine" society emphasizes reasonability, quality of life and human relations. In other words, men are socially expected to be assertive and focused on a goal and material success at all costs, and women are expected to be modest, refined and focused on the cultivation of quality of life. According to Hofstede, as society tends to be a more feminine society, social roles have greater overlap. In other words, both men and women must be modest, refined and in pursuit of quality of life. In such a society, a high level of sympathy towards economic and social legislation that favors the weak is expected (Hofstede, 2001).

The fourth dimension focuses on uncertainty avoidance. In other words, this dimension addresses the degree to which society influences the people in it to deal with situations of risk and uncertainty and also to what extent the organization and those who work in it can live under conditions of uncertainty, non-absolute, and murky situations, surprising and unexpected events. In societies with a low level of avoidance, people are more tolerant of risks and respect different opinions and behaviors. Other societies, where the level of avoidance is high, avoid uncertainty due to the higher importance they ascribe to rules and laws.

The fifth and last dimension classified by Hofstede is long-term orientation. This dimension pertains to the degree to which the time duration (short or long) is the dominant orientation in life. It is related to the conceptualization of the truth. Organizations with a short-term orientation have great respect for tradition. Organizations of this type emphasize the importance of social obligations and statuses. They also encourage ostentatious consumption and expect quick results. In contrast, organizations with a long-term orientation are characterized by thriftiness, restraint and conservatism. Organizations of this type emphasize the need to adjust the tradition to contemporary situations, to be frugal, to persevere in fulfilling roles, and to maintain morality (Hofstede, 2001).

In the future, the challenge of providing care for a multicultural population is expected to be more complicated. In parallel to the aging of the population in the world in general and in Western society in particular, the percentage of migrants in Western countries is steadily increasing and will continue to do so in the future. One in every thirty people in the world is a migrant. About 15% of the population of Sweden is migrants, and in this group above the age of 65, there are about 217,000 people. However, in general, in the countries of Europe, true data on migrants in general and migrants above the age of 65 in particular are even higher. The increase in the population of migrants above the age of 65 requires the health system to have caregivers with cultural sensitivity for the purpose of the promotion of tailored health services for the population of elderly migrants from a multicultural and multi-language background (Hadziabdic, et al, 2015). In a study performed in America, it was prominent that the caregiver of the elderly is expected to have the interpersonal tools to overcome the personal cultural obstacles so he can provide professional care according to the patient’s needs, with the consideration of values and norms, even if they are not identical to those of the caregiver. For the achievement of desired outcomes in the elderly population, through the adoption of quality and effective medical care, the health system is supposed to take into consideration the elderly person’s cultural origins. A medical service that is personally adjusted and considerate of values and norms and given in the elderly person’s language may obtain better health outcomes for him, especially when the caregiver has high sensitivity towards the cultural differences of his patients (American Geriatrics Society Ethnogeriatrics Committee, 2016).

In addition, high cultural sensitivity is needed in medical care and constitutes a basis for the cultural competence of the skilled caregiver who has the emotional tools adequate for the care of the patient. Good cultural expertise in the health worker enables the cultural gaps between caregivers and the patients to be bridged and reduced. The cultural competence/authority of caregivers is the result of the caregiver’s knowledge, attitudes and mental instruments acquired during years of care of people from different cultural backgrounds. The fitness and cultural authority of the caregiver constitute a source of the creation and cultivation of reciprocal relations between the caregiver and the patient. The nature and quality of these relationships are most significant on the way to the achievement of maximum treatment goals (Cadoret & Garcia, 2014; Napier, et al., 2014). In addition, cultural expertise in care is the caregiver’s efficacy in establishing good interpersonal mutual relationships in care; this is the professional ability to build communication with the patient and his family despite the cultural difference that exists. This constitutes a basis required for effective relations between the caregiver and the patient. This is the basis that enables the caregiver, at the start of the care, to understand the unique strengths and the weaknesses of the population of sick people under care (Mobula, et al., 2014). Furthermore, the caregivers who still hold onto the biomedical approach instead of a holistic approach to the patient in his illness without cultural sensitivity may miss important components in the diagnosis of the patient, may undertake ineffective medical intervention, and may obtain poor treatment outcomes (Holmes, 2012). When communication between the caregiver and the patient is flooded with misunderstandings based on language and cultural differences, effective and quality care is not possible following mental and physical harm to the patient. In addition, deficient communication not only builds many additional obstacles between patients and the achievement of better health in advanced age but also strengthens the inequality between migrants and local patients of the same age group (Hadziabdic, et al., 2015).

To prevent the intensification of social divisions (cracks) of this type, it is necessary to strengthen the awareness among patients of the cultural issue. Health workers must promote the accessibility, availability, acceptability and quality of medical services in society for all their patients, considering the personal needs of their patients based on their equality in the required care (Napier, et al., 2014). It is also convenient for the caregiver who comes from a different background from that of the patient to focus on the sickness of the patient and to see the body in the clinic while totally ignoring the cultural, social and family contexts outside of the clinic. The diagnosis and treatment of illness for the most part do not require from the caregiver lengthy conversations with patients. In addition, when the caregiver has not mastered the patient’s language, what remains in his hands is the biomedical clinical tools (Holmes, 2012). If the caregiver chooses to focus on areas convenient for him, then he may miss more important things. Effective caregiver-patient communication aims at the patient’s satisfaction and the promotion of the patient’s health according to his needs and desires. That is, even when the cultural background between the caregiver and the patient is different, the discovery of a shared language for the proper transfer of information is the caregiver’s responsibility during the treatment (Cadoret & Garcia, 2014).

Margaret Mead believed that culture is exactly like language. There are rules of grammar that provide a basis for every structure, and this is like personality, which is based on some psychological traits. An individual is born with a certain basic temperament that responds to conditions and processes that occur in the culture. Therefore, the response of people on one cultural basis changes according to the basic temperament of the individual from birth (Sullivan G. , 2005).

The care of patients goes beyond temperament and cultural values. A person who chooses to treat patients brings with him certain personal qualities. Most physicians who have treated migrants from Mexico volunteered to fulfill the physician's role in the community of migrants with compassion and displayed a strong desire to understand the population under their care. Like Michel Foucault in his book, physicians who have treated migrants support an approach according to which the care of a patient must be individual and must take into consideration the patient's social context and be focused on the patient himself completely (Foucault, 1994). In addition, a quality caregiver is supposed to identify dangerous behavior, such as diet, sexual behavior, and abuse of drugs and alcohol, and to promote education for a healthy lifestyle. A holistic perspective of the patient anchors in it first and foremost the education for healthy behavior that constitutes a basis for the bio-psycho-social approach for the achievement of quality treatment outcomes (Holmes, 2012).

Margaret Mead objected strongly to the idea that there is a significant difference between culture and personality. In her opinion, culture and personality is a whole that cannot be disassembled. A personality cannot exist without a cultural context. In her many works, she showed that culture, and the symbols and customs entailed by it create many dynamic processes for the emotional development of the individual in society; this is how personality is fashioned. Individual difference harms the cultural patterns in the individual's infancy and influences the creation of character at a later age. Thus, an expression of the personality built until old age and its adjustment to the cultural patterns of society may provide explanations of problems entailed by old age that appear in a certain individual (Mead M., 1973). Margaret Mead (1973) was interested in the way in which reciprocal relations exist in society among different people and how people interpret and describe symbols and language. The interpretations given, in their turn, influence the individual's thoughts and behavior. A culture that provides ceremonies, customs, behavioral expectations, symbols and language also becomes an essential part of the understanding of the nature of human existence. The person's thoughts and behavior are nurtured by the culture but are not submissive to it through the surrender of personal individualism (Korkmaz Yaylagul & Seedsman, 2012). There is no doubt that language and behavior that is based on the individual’s culture create a unique environment for the creation of his personal and social experiences and are strengthened in terms of their importance as the individual ages. Thus, multiculturalism and multilingualism bring different challenges in the communication of people in society, especially when there are reciprocal relations in the health arena. Misunderstandings based on differences in languages between the caregiver and the patient not only harm the quality of the medical services that the patients receive but also endanger the patients, especially the population of the elderly. The solution to this problem is a multilingual staff or paid translators (Hadziabdic, et al., 2015). Boughtwood et al. (2011) agree with this argument. Their research indicates that multicultural caregivers come from their community and because of a culture and language similar to those of the elderly person and his family quickly succeed in building good communication, because of a good understanding of customs and cultural requirements. Preservation of a cultural environment through the use of familiar language, customs and symbols during the care of the elderly person, especially when he suffers from dementia, increases the quality of the care of the elderly person and his family. When the health system does not have the option of assigning a multicultural staff for the care of a diverse community of patients, it exposes itself to the development of prejudices among caregivers who as a rule belong to the social majority towards different patients who may belong to a variety of social groups and also to different minorities. The social encounter that exists based on a lack of understanding of social nuances creates prejudices leading to the creation of harmful and humiliating stereotypes, which at the end of the process lead to undesired outcomes in health. These outcomes harm not only the patients but also the caregivers to the same extent. Stereotypes among health workers towards certain groups of patients draw their power from personal barriers, with the common ones including: the patient’s language is different from that of the caregiver, the subculture is different, and the social-economic status is different. In addition, negative stories of the abuse of the health system by certain minority groups causes caregivers to hold stereotypes about the supply of medical services and treatment. Awareness among caregivers of personal and/or group obstacles in therapy may help in the reduction of the influence of social stereotypes towards certain social groups (such as, for example, the elderly) and prevent harm to the quality of the care because of cultural differences between caregivers and patients (American Geriatrics Society Ethnogeriatrics Committee, 2016).

Other researchers who performed studies in the United States agree with this argument. They hold that one of the prominent characteristics of an effective health system that grants its patients services of a high level includes professional experts, leaders and staff who in social and moral terms identify with the population it serves (Mobula, et al., 2014). For instance, in the public health system in Israel on the one hand Jews and Arabs are employed as health workers and on the other hand are cared for as patients in different medical centers. The uniqueness of the experience of nurses, both men and women, of Arab origin who are employed in hospitals in Israel may contribute to a positive perception of the employment of ethnic minorities as health workers for the improvement of the experience of patients from different backgrounds. Thus, with a multicultural population of patients who speak a variety of languages (as in Israel), there is a professional staff, and like the patients, the staff too is multicultural and multilingual (Keshet & Popper-Givion, 2016).

However, modern society for the most part today cannot deploy a multilingual system for the elderly population that does not speak the language spoken by the majority and thus encourages the formation of stereotypes and prejudices that are based on misunderstanding, from which inequality and discrimination grow. The lack of social equality is expressed in a variety of dimensions in modern Western society. In the field of health, these implications are especially destructive. Many examples can be presented: in general, black people have poorer health than whites. The quality of follow-up after blood thinners, the management of chronic illness, and the performance of tests for cervical cancer are not similar between different social groups and change according to ethnicity and culture in society. The gap between social groups and the differences based on multiculturalism must be identified and treated immediately. The gap steadily increases without any intervention and policy on the social level (American Geriatrics Society Ethnogeriatrics Committee, 2016).

One of the groups most harmed by inequality is the population of the elderly. The elderly not only have the highest rate of chronic diseases in the population, but are also characterized by low health literacy, or in other words, their understanding of medical information, as well as their execution of directions, taking of medication, and self-management of chronic illness, is deficient. When a caregiver identifies low literacy among his patients it is necessary to intervene to raise it. Success in doing so will improve health outcomes. When low literacy is associated with a lack of mastery of general spoken language, the caregiver must overcome this problem. There are many different medical centers in multicultural countries that for the improvement of communication between the caregiver and the patient employ professional translators. In other words, even when the elderly person has reduced abilities in spoken language, navigation into the medical world is saturated with professional terms that make it difficult for the elderly person to understand his caregivers' explanations and instructions. Moreover, with the increase in age, there is a decline in the senses that harms communication, especially when it is undertaken in a manner unsuited to people with vision or hearing disorders (such as elderly patients) (American Geriatrics Society Ethnogeriatrics Committee, 2016). Keshet and Popper-Giveon (2016), in their work in Israel, assert that the root of prejudices and the creation of stereotypes do not come from personal obstacles or social-cultural limitations, especially when talking about the health system. Work in Israel indicates that it is necessary to take into consideration difficulties associated with nursing in particular and the care of patients in general since frequently these difficulties harm the values and norms in the homes of the nurses who come from certain minority groups. The main difficulties entailed by engagement in nursing include a stressful work environment, excessive mental demands, the physical cost of the care of patients, overload and mental burnout entailed by the daily engagement with suffering, illness, misery and death. In addition, work in shifts, cumulative burnout, and high professional responsibility, lack of balance between the requirements of the home and the workplace may harm the level of the quality of care, also because sometimes shortness of time, tiredness and mental pressure on the part of the staff may be interpreted as stereotypical thinking towards the patient (Fine, 2012; Keshet & Popper-Givion, 2016).

Goffman addressed the “mixed contacts” between those who belong to a general group and those who have stigma. He maintained that the general population and the stigmatized population are found in a shared “social situation”; in other words, they are in the immediate physical presence of others, whether the encounter is like a conversation or is just shared attendance in an unfocused gathering. It is logical to assume that the moment there is the possibility of making contact of this type, the creators of stigma and the stigmatized will attempt to organize their lives in such a way that will help avoid these contacts completely. It is reasonable to assume that the outcomes, which are more serious than the attempt to avoid this encounter and all the reciprocal social relationships, will harm those with stigma. And this is expected since those with stigma will not succeed in organizing and avoiding the encounter with those who create stigma. When the stigma creators (the general population) and the people with stigma are found in each other’s immediate company, the two sides must directly face the causes and consequences of the stigma (Goffman, 1986, p. 12). Based on Goffman’s work, in social encounters in the health arena health workers, caregivers, physicians and nurses will attempt to avoid every encounter with the elderly and with the elderly who have dementia. In contrast, the elderly in general and dementia patients in particular will not succeed in organizing in such a manner to avoid the encounter with the caregiver. Thus, avoidance of the encounter with the caregiver may harm the essential medical care and the patient will suffer the negative outcomes of the avoidance of the interaction (Goffman, 1986).

In general, a medical cultural framework acquires for itself different languages and customs, so that infrequently a difference is apparent not only between sick people and healthy people who belong to the same subculture but also between people who have different illnesses. This difference derives from the cultural perception of sickness in general and a certain illness in particular (Napier, et al., 2014). For example, dementia is not perceived in certain cultures as a disease but as a situation entailed by aging or a weakness of age. Negative stigma regarding old age in general and dementia in particular, the inability of the health system to cope with difficulties caused by dementia to the patient and his family, and many other factors lead to inequality between elderly patients with dementia and other elderly patients. Stigma and stereotypes that have developed around dementia extend the gap between the caregiver and the patient, and therefore the care of the elderly with dementia is evaluated by the caregivers as less professional, not challenging, and not at all important. In Spain, according to the cultural perception, family needs are placed above the individual needs of family members. Therefore, when in one family the parents are diagnosed with dementia, the care of the patient is undertaken by his family. Frequently, the illness is not even diagnosed because of the cultural perception in the population and the lack of referral to the health system. Dementia is perceived as an inseparable part of the natural process of old age. A family takes upon itself the care of the elderly person, including economic expenditures that are brought about by dementia. Cultural perception is further strengthened in parallel to the absence of health services suited for the population of the elderly who suffer from dementia. Most families do not consider appealing to the authorities for help, since they feel that the transfer of the elderly person from his home at the end of his life constitutes neglect and abandonment. In addition, a perception regarding the care of the elderly person until the day of his death enrooted in certain cultures (in Spain, for example) causes family members to decide to provide end-of-life care within the walls of the home as the only option possible from their perspective. The option to move an elderly parent to an institution is not at all possible, especially when care services are at a poor level (Boughtwood, et al., 2011).

Erving Goffman held that an individual who discovers at a later age his belonging to a group with stigma and consequently begins to see himself as flawed develops a lack of satisfaction towards himself and finds it difficult to re-define himself. This discovery, of belonging to a group that is rejected because of stigma, causes harm to the individual’s self-esteem and an extreme change in the outlook on his past and his future. In most cases, the discovery of belonging to a group with stigma entails a new situation of illness. Hence, according to Goffman, the medical profession will have a special role in the life of the patient and his family (Goffman, 1986).

When the individual acquires stigma late in his life, the discomfort he feels in his new situation can slowly give way to discomfort regarding the previous social relationships. The new acquaintances can see him simply as having a certain flaw, while the acquaintances before the stigma cannot act towards him as the individual would like, because they adhered to what he was beforehand, before the discovery of the defect/illness (Goffman, 1986). Therefore, it is possible to conclude that the elderly person's family with the discovery of the new illness of dementia prefers coping with the problem on its own and distancing, as much as possible, the elderly person from the creation of stigma that will harm not only the elderly person but also his family. Keeping the diagnosis of dementia a secret from the close environment of the elderly person's family enables the stigmatization of the entire family to be avoided. This is not at all surprising: dementia in its initial stages is expressed through harm to memory, which also implies old age. Thus, according to Goffman, when stigma (illness) is invisible and known only to its owner, who keeps it a secret, he can disengage from his social contacts and still function relatively freely in society. Furthermore, Goffman cautions that the individual who pretends or conceals certain traits from society at large may reveal other attributes and enable the individual's affiliation to a group that suffers from social stigma. The person who pretends or conceals may suffer from the classic experience of exposure in reciprocal relationships that exist face to face, when the individual attempts to conceal his weakness, others present may betray him. In the end, the individual who conceals the weakness or the trait that may affiliate him to the group with stigma may be found in a situation of demand for real disclosure by people who have already discovered it. This possibility can be formally established, as in the case of the investigation of mental health (Goffman, 1986). The elderly person, who is diagnosed with dementia, may be an example of Goffman's assertion.

A study performed in Switzerland indicates that with the individuality and independence in decision-making that so characterize modern Western society, the transfer of the elderly person to an institution is necessary and constitutes the only choice that exists today for a modern family. Moreover, the decision of the elderly person to move to an institution, when he is no longer able to be independent, is a decision expected in the cultural context of modern Western society (Soderberg, et al., 2012).

Goffman also maintained that when the individual belongs to a group with social stigma, for adjustment he needs to accept and not reject it. The person with a stigma is asked to behave in a way that is not burdensome for others, and social distancing and closure are the strategies most required by general society along with the stigmatized. Goffman emphasized that the special situation of the individual with a new stigma that was acquired is that the society to which he belongs sees him as different. This difference appears normal from the side but does not allow the individual to belong to the general group (Goffman, 1986). The elderly in general and dementia patients, in particular, constitute an example of Goffman's argument.

In addition, when the care of the elderly person yields poor outcomes, the root cause will always be a failure in communication between the caregiver and the patient. This is seen especially when the information is not conveyed to the patient at all or when it is conveyed in parts. In addition, sharing information and knowledge between the patient and the caregiver is supposed to be done through the creation of a clear language and cultural basis for both sides. Thus, for example, when old age is perceived culturally as an illness and as a combination of illnesses that accompany it, the caregiver's authority and cultural sensitivity will help him minimize the patient's harm and suffering by neutralizing the mistaken making of decisions without consideration of the patient's expectations, because of the creation of communication based on cultural understanding and respect towards the patient and the cultural perception of old age (Napier, et al., 2014).

According to researchers in Switzerland, effective and culturally sensitive communication with the building of effective reciprocal relations between the patient and the caregiver begins from a shared language that constitutes an initial bridge between the caregiver and the patient. Therefore, the use of translators, while welcome, is not sufficient. However, the identification of the needs of the elderly patient begins with the use of his language through the consideration of his sensory ability. The caregiver must evince responsibility in the care and enable a basis of understanding even if there is a need to involve family members or professional translators

(Hadziabdic, et al., 2015). There is no doubt that a shared language and cultural-social understanding and tolerance between caregivers and patients are the most important things in the achievement of results of good quality. However, if social-cultural tolerance and effective coping with prejudice on the part of the caregivers need improvement then social-cultural tolerance on the part of the patients towards medical workers is not discussed at all, as if it does not exist or is not sufficiently important. Work undertaken in Israel indicates that nurses from minority populations are subjected to insults and verbal violence by patients only because they belong to the social minority (Keshet & Popper-Givion, 2016). Although cultural sensitivity and good communication instruments among caregivers help destroy the obstacles in communication in the health arena, when a social arena cultivates differences between groups, the obstacles constitute a significant disruption to the care. Therefore, a cultural authority among caregivers is not only the collection of instruments necessary for the care of migrants and minorities but is also supposed to be a main character trait of the caregiver himself (Napier, et al., 2014).

There is no denying that language constitutes a cultural basis and influences interpersonal communication in the culture and between cultures; it also constitutes a basis for the achievement of better health throughout life and especially during old age. Therefore, the following finding in a work conducted in Israel is not at all surprising: the multicultural nursing staff, which speaks a variety of languages, responds to greater quality and sensitivity to the multicultural community of patients (Keshet & Popper-Givion, 2016). A work performed in the United States shows similar findings. As the nursing staff is more diverse culturally, the care of the patients is better. In addition, when nurses, both men and women, received annual training for dealing with patients in care, they tended to be more tolerant of patients from different backgrounds and displayed better listening abilities and openness regarding different cultures. In contrast, nurses who did not take training courses for tolerance were observed as less tolerant towards patients from different cultural backgrounds (Isaacson, 2014). Campos (2015) extends this argument. In her opinion, social interpersonal interaction constitutes a cornerstone of the individual’s physical and mental health. A person is a social creature and his good health depends on his social abilities from an early age.

Therefore, as the individual is exposed to more social relationships, he will tend to be more skilled in interpersonal communication and will have a better ability to adjust to multiculturalism in society. When referring to the caring professions, a curriculum that teaches tolerance and cultural sensitivity is important (Isaacson, 2014). Work performed in the United States found that alongside innate and acquired communicational abilities in early childhood, a staff with a motivational component often displayed abilities of cultural sensitivity towards their patients, were more humane in work, and identified more easily the limitations and obstacles in the treatment. Conversely, the staff of caregivers who were influenced by stereotypical attitudes were less motivated to help patients and appeared in their eyes to be less humane (Mobula, et al., 2014).

Based on research studies performed on other professions, work with emotional and physical load over time is supposed to cause burnout and professional attrition. However, engagement in nursing is not similar to other professions and even constitutes a professional phenomenon. On the one hand, nurses are found to a feel great mental load and report certain levels of burnout throughout the years of work, while on the other hand, nurses present high rates of a feeling of personal empowerment and emotional satisfaction caused by the profession. However, research studies among health workers in multicultural societies did not adequately measure differences (if there are any) between caregivers in a multicultural staff. In other words, the nursing staff, regardless of their social affiliation or origin, is united around values shared by the entire staff, such as care on a high level for every patient according to his needs, equal attitude towards patients, and so on. Differences in the perception and attitudes of caregivers from different cultural backgrounds were not examined in research studies (Keshet & Popper-Givion, 2016). Isaacson (2014) furthers this argument, stating that there are many aspects of multiculturalism and cultural authority. It is important to understand that it is impossible to specialize in all cultures. Health workers expect cultural humility. In other words, regardless of the patient’s cultural belonging, a skilled and professional caregiver takes upon himself the responsibility for the quality of the reciprocal relations in care, through active attention to the patient from a different background alongside high self-awareness regarding personal thoughts. In addition, researchers from the United States emphasize the caregiver's role in the health system, according to which the construction of a social-cultural bridge and the elimination of gaps between patients of diverse backgrounds is a basic requirement of the caregiver's role, alongside other duties, such as support in difficult physical and mental situations, entrepreneurship, promotion of health, guidance and education for a healthier lifestyle (Mobula, et al., 2014).

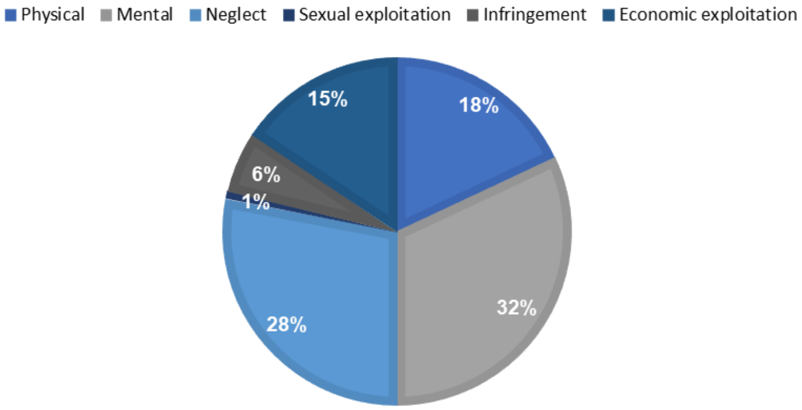
4.7. Violence in elderly patient-caregiver interaction.

Contemporary Western society is confronting the widespread presence of violence that affects all layers of the social fabric. This troubling trend is on the rise, incurring profound moral costs. As a result, children, women and increasingly, seniors are falling victim to various forms of violence. These victims endure abuse, incarceration and disrespectful treatment, with some elderly individuals tragically succumbing to physical assault, neglect and inadequate medical care. The aging population has brought a range of challenges that were previously overlooked, among which is the violence directed at older adults. Although there is no universally accepted definition, the most recognized understanding of violence against the elderly is provided by the World Health Organization (WHO).

According to the WHO, the phenomenon of violence against the elderly is a one-time event or repeated occurrence of inappropriate activity in a relationship of trust that causes some discomfort or damage to the elderly. Initially, this definition was adopted by the WHO as early as 1995 from a legal position paper obtained in England (Lacher, et al., 2016; Wang, et al., 2015; Formosa & Mackowicz, 2019).

Researchers have argued that the absence of a clear and unambiguous definition of violence against the elderly creates problems and causes ambiguity regarding many cases in which seniors suffer from physical and mental discomfort, but are not defined as victims of violence (Melchiorre, et al., 2017). Pillemer et al. (2016) concur with this argument and expand the definition of elderly abuse by arguing that according to the classical and accepted definition of violence against the elderly, a critical point is missing - the responsibility of the caregiver. In other words, violence is not only an act or a case that causes discomfort or harm to the elderly but rather a failure of the caregiver to meet the basic needs of the patient and/or an inability to provide the elderly person with an adequately safe environment for the rest of his or her life. Thus, the elderly person as a result of violence suffers from damage or injury, deprivation and unnecessary risk. The caregiver is solely responsible for the harm that occurs or fails to prevent it from happening (Pillemer, et al., 2016).

Figure 13: Reports on elder abuse and neglect by types of abuse in Israel, 2014.



(Angelman & Ben-Haim, February 2023)

Indeed, violence and abuse of the elderly has many faces. The main types described in the literature are psychological, financial, physical, sexual and neglect (Gutman & Yon, 2014; Formosa & Mackowicz, 2019). Mental abuse includes verbal assault, intimidation and threats, verbal humiliation, denial of contact with family members, and any situation that results in the discomfort or emotional harm of the elderly person, without any physical contact. Another form of violence is financial exploitation which is defined as the inappropriate use of assets/economic resources and other goods belonging to the elderly (Hoover & Polson, 2014).

The abuse involved in financial exploitation is not identical to other types of elderly abuse. Often, there is a blurring of the boundaries between an elderly person's giving of his own free will and financial exploitation without the person's knowledge or even against his will (Melchiorre, et al., 2017). Another kind of abuse is defined as an act of causing pain or physical harm to the elderly person. Moreover, sexual violence against an elderly person is: touching, penetrating, and/or engaging in sexual activity against the will of the elderly person or a situation in which the elderly cannot refuse or agree (Dong & Simon, 2015; Ben Natan & Tabak, 2013).

Furthermore, neglect is also a form of violence. To understand this type of abuse, Yunus et al. (2017) divide incidents of neglect among the elderly into two categories.

The prevention of daily-needs support (cooking, bathing, clothing, walking, climbing stairs); The lack of sense of self-security, hygiene, the lack of medical treatment, lack of clean clothes according to the weather, lack of food, and inadequate food that does not meet the needs of the elderly. Respectively, the neglect of formal therapists and family members is not merely an increasing social problem, it is a violation of the elderly's rights and should be seen as a dehumanization of society (Dong & Simon, 2015)**.**

Formosa and Mackowicz (2019) add spiritual violence to the wide range of types of violence against the elderly. They maintain that the disruption of their prayer or the prevention of their access to religious services and religious objects to which they were accustomed constitutes violent behavior towards them, reduces the elderly people's freedom and harms their quality of life (Formosa & Mackowicz, 2019).

When the abuser is a relative, elderly abuse will only be reported in extreme cases that cannot be concealed, such as severe physical harm or death. In contrast, when an elderly person is treated by professional health caregivers, usually involving multiple caregivers, there is a higher likelihood that incidents of violence against the elderly will be reported (Lacher, et al., 2016). Research conducted in Israel reveals that the cooperation of abuse victims, especially when caregivers are relatives, is a challenge. The fear of an elderly person over the intervention of authorities is a significant barrier to the identification and treatment of abuse (Shahak, 2015).

The first case of violence was published in the literature about 40 years ago (Lacher, et al., 2016, p. 1). Nonetheless, despite the many violent incidents currently reported in the media, there is no satisfactory discourse on the issue. Violence against the elderly remains a taboo and is therefore unjustly placed low on the social agenda. This may not come as a surprise, because the prevalence of the phenomenon is undervalued as real data are not published for the general public. Furthermore, the gap between the actual assessment and the numbers released has severe implications for the elderly, their families and the public health system. Hence, to evaluate the phenomenon correctly, it is necessary to map its prevalence in society. Although data collection currently takes place, it changes from one institution to another and from one country to another (Lacher, et al., 2016; Yon, et al., 2017). For example, in one epidemiological study conducted in England in 2006, the prevalence of elderly abuse in this year was 2.6%. In Switzerland, data were only partially collected and were not reported at all (Lacher, et al., 2016). Worldwide, the average prevalence of violence against elderly people is 15.7%. In Western society, out of every six elderly persons, one becomes a victim of abuse. Thus, 141 million elderly people are victims of the violence of people around them, out of a total of 901 million adults over the age of 60 (Yon, et al., 2017).

Similar data are also presented in the data from Poland. The frequency of violence against the elderly ranges from 1% to 35%. According to the researchers, the problem is that about 80% of the total number of cases of violence that occur are not reported at all. The lack of reporting derives not only from the isolation of the elderly but also from the lack of desire on the part of the caregivers and the general population to report the suspicion of violence or neglect (Formosa & Mackowicz, 2019).

Between 3 and 27.5% of the elderly people in the modern world experienced psychological, physical or sexual violence and/or neglect at least once in the past year (Gutman & Yon, 2014; Yunus, et al., 2017). Similar data are also evident in other studies. The prevalence of violence in Europe ranges from 2.2% in Ireland to 61% in Croatia. In some studies, about 30% of the elderly have been affected by some violence or experienced events that involve many types of abuse at the same time, with sexual assaults being the least reported form of violence against elderly people. Only 1-2% of all abused elderly persons reported sexual abuse (Teaster, et al., 2015). Pillemer et al. study (2016) indicates that the incidence of gender-based violence ranges from 0.04-0.8%; in the United States it was around 0.50%, and in European countries around 1% was reported as part of a physical injury when the victim has no possibility of concealing it (Pillemer, et al., 2016).

In the opinion of many researchers, to achieve maximum accuracy in mapping the prevalence of violence against elderly people, it is essential to divide psychological, rather than physical, types of violence. Thus, mental violence/abuse is one of the most common forms of violence against the elderly. The prevalence rate ranges from 27.9% to 62.3% and is higher than presented in other studies that do not distinguish between types of violence (Dong, et al., 2014). In the work of Pillemer et al. (2016), which reviewed studies in Canada, the United States and Europe, emotional abuse ranges from

0.75 to 27.3% and is also the most common type of violence against the elderly. These findings are supported by a study in Spain, with a breakdown of cases of violence (physical, financial, mental), showing that most elderly people (91%) suffered from emotional violence, compared to 2.9% who were victims of physical violence. Some 46% of those reporting emotional abuse experienced such abuse at least once in the short period before the study. However, the most common type of emotional abuse is neglect. The significant challenge in mapping the phenomenon of neglect among the elderly is the considerable gap in the frequency of the phenomenon among different countries in Western society. For example, findings in Spain showed that 66% of the elderly reported neglect by a primary caregiver (Martins, et al., 2014). About 5.1% of the elderly are neglected in the United States, compared to 25% of the elderly in Israel, and the difference in the data can be explained not only by differences in research methods but also by the difficulty in identifying the phenomenon. The neglect of the elderly is less institutionalized in Western countries. Western society, with its demand for privacy for adults, blurs the fine line between the desire of the elderly for privacy, and their inability to live alone (Ayalon, 2014).

Compared with neglect of the elderly, neglect of children is an evident, unambiguous phenomenon. To accurately reflect the neglect of the elderly, there is a need for the active presence and involvement of several caretakers as a source of reliable and accurate information (Ayalon, 2014). The findings of a study in Israel that investigated the phenomenon support these data. Out of 513 cases of elderly neglect, about 70% of respondents reported witnessing instances where another staff member withheld daily care from elderly individuals. This type of neglect was observed to be most common in the institutions where they worked. (Ben Natan & Tabak, 2013).

Furthermore, when the care of the elderly is provided at home by a single caretaker who bears the sole responsibility for the treatment - a report to the authorities regarding neglect is not reliable or sometimes does not even exist. This is explained by the concerns of caregivers about losing their livelihood if they report (Ayalon, 2014). At the same time, there is an increasing trend of reporting to the authorities cases of abuse from which the elderly are harmed. For example, in the study of the identification and evaluation of abuse and neglect of the elderly by their caregivers, it was found that between 2000 and 2004, the percentage of reports to the authorities about violent incidents increased by 16% compared with previous years (Hoover & Polson, 2014) .

Other researchers support this argument. According to Formosa and Mackowicz (2019), the trend of increases in reporting regarding violence against the elderly is a modern phenomenon that characterizes many countries. In some countries, for example, Ireland, the rate of reporting an event of violence against the elderly rose 22% in three years (from 2008 to 2011) (Formosa & Mackowicz, 2019).

An increase in reports may stem mainly from an increase in the incidence of violence. In Israel, the number of elderly patients treated for abuse and neglect in abuse prevention units increased from 4,556 in 2010 to 5,318 in 2014. While the data do not reflect all abuse in the country, they present reports of abuse in local authorities where elderly abuse prevention units operate. It should be noted that out of the 255 existing bodies in Israel, only 55 have units dealing with violence against elderly people. In other words, in Israel too, the existing numbers of cases of violence against the elderly do not reflect reality (Shahak, 2015). Despite the official figures in various Western countries that show an upward trend in reporting cases of violence against the elderly, in practice, only 1 out of 24 cases is reported to the authorities (Rosen, et al., 2016). Similarly, in Canada in 2009, the police reported 7871 cases of violence against adults older than 65, out of about 4 million people in this age group. Although only 17% of all cases reported to the authorities have been brought to court, it can be concluded that only a few attackers are indeed punished for violence against the elderly (Wang, et al., 2015).

This figure comes as no surprise. About 40% of the victims are family members who care for the elderly. The elderly person will be afraid to report violence to the authorities due to his/her daily dependence on the caregiver, especially when the dependence is physical and/or financial. Dependence generates concerns that if the caregiver, especially a family relative, is arrested or barred - the elderly person may have to move to an institution (Lacher, et al., 2016; de Mooij, et al., 2015; Ruelas-Gonzalez, et al., 2016). According to Ayalon (2014), there are a limited number of sources of neglect reporting among the elderly: the elderly, family relatives, and a formal caretaker if present. This explains the sub-reporting and underestimation of elderly neglect. Not only do concerns stop the elderly from reporting inappropriate treatment. The lack of cognitive, mental or physical abilities constitutes an additional obstacle to reporting. Similar patterns occur for other types of violence toward the elderly (Ayalon, 2014).

Harries et al. (2014) emphasize that there are various types of violence whose occurrence is even more difficult to prove than neglect, even in cases where the victims are reporting. The study shows that the rate of victims of financial abuse ranges from 0.7% to 14.4%. However, in practice, it is significantly higher. Underassessment in the case of financial exploitation stems not only from the lack of reporting by the elderly themselves but also from the silence of caregivers who are witnessing what is happening and are afraid to mistakenly accuse the caregivers involved in economic abuse and thus become the victim of bullying from colleagues (Harries, et al., 2014).

Hence, lack of reporting, lack of tools to prove financial exploitation, and the "silence" of staff or close relatives - contribute to the blurring of the real dimensions of the phenomenon of financial exploitation in particular, and abuse in general. The neurological cognitive or mental condition of the elderly, lack of cooperation and fears of formal caregivers are not the only barriers to reporting cases of violence to the authorities. Fear of emotional rejection, shame, a vague sense of a dead-end, and many other factors prevent elderly people from discussing issues that may cause discomfort or dissatisfaction in their caregivers (Hoover & Polson, 2014).

Scientists who study the phenomenon of violence toward the elderly in Mexico warn that the aging of the population will not only increase the incidence of violence but will double its frequency and intensity, and this is a logical development. A drastic decline in the ability of the modern family to support the elderly, alongside the aging of society, leads to a rapid decline in the value of the family in contemporary society and an increase in phenomena such as abuse. The burden of supporting the elderly which is placed on family members in the absence of adequate coping tools changes old cultural habits. While the family fights for its existence in modern society, and for this purpose, a structural change is required to survive, the family unit is reduced, and the elderly are pushed out of a traditional family framework (Ruelas-Gonzalez, et al., 2016). A daily struggle with financial difficulties, inevitable poverty despite the struggle, overcrowding due to multiple generations, lack of privacy, etc., will be the result of an outbreak of violent events as an inseparable part of interpersonal communication. This kind of violence is not aimed at anyone specific and it is not characteristic of a particular country. It is like a pressure cooker that has created vapor. The vapor must be released so as not to cause an explosion. So, violence is the result of the natural development of difficult life conditions and stress (Pillemer, et al.,2016).

Indeed, alongside various cultural changes in modern Western society, some values and norms remain. For example, in Italy, the subject of violence against the elderly is a social taboo. Thus, families in a modern society maintain privacy, and what happens in a family does not leave its framework. It is only natural that close relationships can lead to the expression of aggression. Therefore, when aggression does not cross the borderline and becomes extreme violence, everything remains within the family. Conversely, when the results of aggression are severe physical injury or death, the report goes out to the authorities. On the other hand, under-evaluation of all forms of violence among the elderly is a universal phenomenon that embraces the entire world. The differences in the prevalence of this phenomenon among different countries stem from a wide variety of factors, although the main difference between them is cultural differences between different countries (Melchiorre, et al., 2017).

Almost naturally, an atmosphere of neglect and social aggression was created for the elderly. Social media, which is a magnifying lens of social phenomena, highlights the aggressive way in which society communicates with the elderly. This communication becomes acceptable and the only one known to younger generations. The media, which could have been a shield shaping the behavior of the younger generations, strips old age of its dignity and eliminates the needs of the elderly, contributing to the social marginalization of this age group. Moreover, this is how legitimacy is built for violence against the elderly, and there is also harm to their sense of security in different areas of their lives (Illouz, 2007).

Mapping the phenomenon of violence against the elderly is based on an understanding of the factors that constitute triggers for violence. One of the leading causes of the growing phenomenon of violence against elderly people is ageism. Discrimination and intolerance draw their power from the values and norms of a modern Western society where intolerance towards the elderly is reinforced by the formal social systems that sustain it. Lack of familiarity with old age forces the rest of the population to act out of prejudices that are irrelevant today. The phenomenon of violence does not stem from the weakness of the elderly, but from the lack of social ability and fear to be tolerant of the outcomes of the aging of the population, both on a personal level and on a social level (Gutman & Yon, 2014).

Moreover, the media in a modern Western society encourages the creation of values and norms of violence and free expression of aggression, while eliminating values of tolerance and respect, especially against weak social groups, such as the elderly. Further, a difference between economic and social policy causes the creation of socio-economic inequality, which is manifested in violence against the elderly, especially when they are economically dependent on other age groups and are perceived at the social and family level as an unnecessary burden (Melchiorre, et al., 2017).

Pillemer et al. (2016) came to a similar conclusion in their study. Violence against the elderly has a prominent cultural and social component. For example, in traditional societies, a widow must remarry to preserve her property, or naturally, her family absorbs her means and leaves her without property. Similarly, in modern Western society, economic exploitation of elderly people is also a social norm. Financial support for children has been part of cultural standards for so long that the use of the elderly's economic means seems natural and even necessary, even when children become adults and parents become elderly with limited means (Pillemer, et al., 2016).

Violence remains, despite cultural changes between countries, a widespread problem. In the opinion of Israeli researchers, a system of formal rules and methods for treating the elderly creates an abysmal distance between the care staff and elderly patients. As a result, two separate social-cultural worlds are created, with limited communication between them. The team has a sense of superiority and has control and influence. On the other hand, elderly people have a sense of inferiority and are weak in front of a formal and useless system of rules. Thus, one of the salient consequences of power disparities in this equation is violence against the elderly (Ben Natan & Tabak, 2013).

Other factors that encourage violence against the elderly are characteristics associated with the victims. For example, young seniors are more likely to be affected by violence than older adults. A possible explanation for the fact is that young seniors still live with their spouses or children, and these are the most common attackers. Furthermore, one of the factors that encourage violence is the background of chronic diseases of the elderly, such as mental illness, especially depression and anxiety, and physical disabilities caused by disabilities. In other words, chronic diseases that cause the elderly to develop an extreme dependency on their caregivers increase the chances of an elderly person being harmed by violence from close therapists (Lachs & Pillemer, 2015; Melchiorre, et al., 2017; Alon & Berg-Warman, 2014).

Another cause of violence is gender. Older women, like other age groups of women, are more vulnerable to violence than men, especially being physically and sexually assaulted (Lachs & Pillemer, 2015; de Mooij, et al., 2015). A masculine figure in modern society is presented as having influence and physical strength. Indeed, more women than men become victimized when the attacker is a family member (Ruelas-Gonzalez, et al., 2016).

However, at a later age, there was no statistically significant difference between men and women. Men of advanced age are used similarly to women in their age group. Similarly, women like men are affected by various types of violence on the part of those around them. This can be explained by the appearance of signs and symptoms of physical disability, a decline in health status and the growing dependence of an elderly person on caregivers as they age (de Mooij, et al., 2015; Melchiorre, et al., 2017).

Moreover, men from their birth to the day of their death are under social pressure to behave according to a pattern expected of them ("being a man"). In old age, men are physically weakened and at increased risk of violence of various kinds, even more than women of their age. In addition, the elderly (men) are more likely than women to hide incidents in which they are victims of abuse because the expression of these complaints is not "masculine behavior". Gender stereotypes rooted in society regarding the roles and behavior of men and women weaken the understanding of violence towards the elderly. Therefore, the study of the phenomenon requires neutralizing their influence to obtain original findings (Melchiorre, et al., 2017).

Additionally, elderly people living in the community are more affected than elderly people who live alone or with their families for many generations. This can be explained by multiple social connections and residential density. Also, the chances of an elderly person who has already been hurt in the past are rising, and abuse may repeatedly occur, especially with the same therapists (de Mooij, et al., 2015).

In contrast, a study that investigated violence against elderly people and compared it in urban and rural areas found that elderly people living in urban areas experience abuse more frequently than those living outside the city. There may be additional intervening variables that have not yet been mapped in studies of violence in the elderly (Yunus, et al., 2017). Town or village, community, or isolated residence - it is essential to see the availability and quality of social connections that can give the elderly the support needed for a healthy and safe old age. Thus, the low availability of social/family support and the absence of high-quality social contacts increases the chances of elderly people being affected by violence. On the other hand, the presence of an extensive network of close, high-quality relationships in the life of an elderly person constitutes a protective factor against neglect, exploitation and physical violence. True, high-quality family relationships are the result of many years of investment by an elderly person in social relationships. They also constitute a significant protective factor against violence among the elderly (Melchiorre, et al., 2017). Another characteristic of increasing violence against the elderly by caregivers is the early transition of an elderly person to an institution. For example, patients with dementia are being transferred to an institution for the elderly at relatively young ages (Ayalon, 2014).

When the subject of violence is raised in the public debate, it is customary to place the victim, at the center of the phenomenon. It is essential to understand that alongside the victim there is someone who takes an active part - the offender. The opinion of many researchers who focused their work in search of the characteristics of the offender saw that elderly people are hurt more in close family relationships. In other words, among caregivers who harmed the elderly, there is a high prevalence of spouses and children of the elderly themselves (Lachs & Pillemer, 2015; de Mooij, et al., 2015). Teaster et al. (2015) reached a similar conclusion. In their opinion, approximately 89%

of all elderly people are abused at home when the offender is a child or a personal caregiver. These are people who are naturally expected to bring confidence, training, and support to an elderly person’s life. In addition, the average age of the abuser is 57.5 years (Teaster, et al., 2015). It is also believed that male caregivers are more likely to be identified than women with violent behavior towards patients, mainly when physical attacks are associated with substantial bodily harm. However, findings in the studies indicate equality between men and women in demonstrations of violence against their patients or lack of statistically significant gender differences between caregivers. Moreover, in one of the studies that examined women and men in the care of relatives, it was found that women (75%) were more violent in treatment than men (67%) (Melchiorre, et al., 2017).

Indeed, in the findings of a study that investigated sexual exploitation in institutions for the elderly, it appears that most of the offenders (about 91%) were men. The gender of the offender varies according to the type of violence being investigated (Teaster, et al., 2015). When identifying the characteristics of a violent therapist alongside the kind of abuse, professional caregivers, those who undergo some classification for their work, and informal caregivers, must be treated separately. For example, informal caregivers who showed violence towards the elderly had financial difficulties, and most of them were unemployed for a long time. Also, about 2/3 of them suffered from drug and/or alcohol addictions, and from various mental illnesses. In contrast, formal caregivers who were violent toward patients were characterized by a sense of burnout, high job drop-out rates, high turnover of caregivers due to unsatisfactory conditions, increased occupational morbidity and decreased morbidity (Alon & Berg-Warman, 2014; Ayalon, 2014).

According to Ben Natan & Tabak (2013), despite the erosion in the work of therapists and emotional stress, caregivers with many years of experience and seniority acquire more positive attitudes toward the elderly and do not express aggression or violence. On the other hand, the less experienced a caregiver is, the more resentment and hostility will be conveyed toward the elderly. Thus, violence by the caregiver against the elderly is not only the result of erosion in treatment and low satisfaction with the workplace and the conditions of employment there. Other factors related to the caregivers are stress, depression, anxiety, excessive use of alcohol, social isolation, and hostile relationships with an elderly person, which may be triggers for a violent outburst of the therapist against an elderly person (Dong, et al., 2014).

Also, the chronic illness of a caregiver together with the difficulties involved in working as a caregiver, and prolonged fatigue due to multiple hours of work - can lead to violent outbursts of the caregiver against the elderly person whether it is a family member or a formal therapist. In other words, the demanding conditions of therapist work, the mental state of mind, and so forth, do not explain violence exclusively. These are essential elements, but they are fundamentally based on societal values and norms. Thus, an expression of violence or aggression on the part of the therapist is the result of the society and culture of the therapist who encourages violence and the use of force against the weak. Also, not everyone can take care of the elderly. There is a significant personal component in the ability of a person to take care of the elderly. However, adequate research has not yet been conducted on this subject (Martins, et al., 2014). Furthermore, the dependence of the caregiver on the patient, which is usually financial and characterizes families, raises the likelihood of violence on the part of the therapist (Alon & Berg-Warman, 2014). Other researchers believe that characteristics that encourage violence in patient-therapist relationships, especially when it comes to families, are based on the lack of harmony in the family tree, which is often interwoven with poor communication. A group of elderly people with cognitive decline and/or who suffer from dementia deserves particular attention in the discussion of elderly abuse. This group is more vulnerable to violence of all types than the general population of the elderly (Gutman & Yon, 2014; Dong & Simon, 2015). Findings from a study in Denmark showed that about 25% of elderly people who have mental illness and/or cognitive decline in the year become victims of violent crime, while only 3% of the general population in the same period suffer from similar events. Also, about 30% of the elderly who suffer from cognitive decline experience non-physical violence, compared to 8% of the general population who have been affected by non-physical violence. In other words, elderly people suffering from cognitive decline, compared with the general population, are five times more likely to experience violence (de Mooij, et al., 2015). Similar data were found in other European countries. For example, the incidence of verbal abuse against the elderly in the general population ranged from 0.3% in Spain to 3.2% in Switzerland. However, among the elderly with dementia, between 34 and 62 percent were verbally assaulted. It was also found that elderly people over age 85 with Alzheimer's were 4.8 times more likely to be verbally assaulted than elderly people with average cognitive decline (Melchiorre, et al., 2017). The situation is similar among this group of patients in other types of violence. For example, about 70% of elderly people who fell victim to sexual abuse were elderly with cognitive decline or had dementia with a declined ability to communicate the abuse (Teaster, et al., 2015; Harries, et al., 2014). For example, a study of 284 cases of sexual abuse found that about 60% of the elderly suffered from cognitive decline or dementia (Dong, et al., 2014).

It should be noted that between 18 and 35% of seniors suffering from cognitive decline or dementia have aggressive behavior toward their surroundings. The aggression that characterizes the behavior of dementia patients stems from the loss of memory and other cognitive functions that characterize this disease. An outbreak of violent behavior towards the therapist by the elderly man stems from a lack of communication skills of the therapist himself with dementia patients. Most therapists of dementia are unaware of the behavioral manifestations of this disease. The lack of necessary tools for identifying and treating the violent behavior of dementia patients, low professionalism, and the lack of proper and targeted training of caregivers contribute to an increase in the prevalence of violent conflict in treatment between dementia patients and patients. For example, in one study, only 38% of therapists learned strategies for treating violent behavior from dementia patients, and only about 70% knew how to avoid conflict with these patients. True, the situation is not encouraging in all institutions for dementia patients (Wharton & Ford, 2014).

An expression of aggression in the relationship between caregivers and patients is not only part of the illnesses of the elderly. First of all, aggression and violence is an unavoidable characterization of close ties between caregivers and patients which arise in difficult treatment situations and long periods (Wharton & Ford, 2014; Dong, et al., 2014). Factors of violence associated with patients with dementia raise some triggers. These include pain that is not treated at all or is not adequately addressed, a decrease in the sensory ability of the elderly (vision, hearing), changes in the patient's physical environment, noises, a small room space with closed doors, and low quality of communication by therapists. Moreover, the onset of aggression by elderly people with dementia against caregivers is one of the significant daily challenges in the treatment of patients with dementia, especially in the early stages of their illness (Wharton & Ford, 2014). An additional factor in the expression of aggression by patients with dementia is the long-term provision of a multiplicity of drugs, even psychiatric treatments, without supervision and control (Lachs & Pillemer, 2015).

The care of elderly people with dementia is known as particularly difficult for caregivers and is considered to increase the sense of burnout. The significant cognitive decline, loss of functioning, and extreme dependency on the caregiver leave no choice for the family, but to bring the elderly to an institution for the rest of life. In other words, on the one hand, to provide high-quality treatment for the elderly with dementia, it is essential to preserve the familiar environment. On the other side, the challenging behavior that involves the aggression of the elderly patient together with the dependence on daily assistance drives the family to transfer the old person to an institution (Wharton & Ford, 2014). The caretaker’s good health is especially important in the care of an elderly person suffering from dementia. For example, depression and anxiety among therapists are a risk factor for violence in general, but especially for the elderly with dementia. In addition, low-level mental and physical health and a lack of social support among caregivers endanger the treatment of the elderly, especially in the challenging treatment of an elderly patient with dementia (Melchiorre, et al., 2017).

The phenomenon of violence in general and violence against the elderly in particular raises a high ethical and moral price, but not only. It requires many social, human and economic resources. At the same time, the most severe and dangerous consequences fall in the area of health, primarily when violence is directed at the elderly (Ruelas-Gonzalez, et al., 2016). The psychological impact of violence among the elderly leads to an increase in depression, anxiety and self-neglect (Lachs & Pillemer, 2015; de Mooij, et al., 2015). According to the findings of a study conducted in Switzerland, elderly people who suffered from emotional abuse suffered from severe sleep quality disorders. In contrast, healthy aging was characterized by a high quality of sleep. Long-term sleep disorder is a cause of health impairment and is the first link in a chain for patients. It is usually characterized by violence without physical injury from the analyst, such as emotional and economic and/or neglect. Regular and consistent sleep quality monitoring may help the clinician identify the impairment of the elderly and thus contribute to reducing more severe health consequences in the future (Yunus, et al., 2017).

Furthermore, elderly people who experienced some violence suffered from a wide range of severe health problems that without treatment threatened to become more chronic than in other age groups. For example, victims of violence were characterized by various metabolic disorders, lack of control over closure, and other problems in the digestive system (Yunus, et al., 2017; Dong & Simon, 2015). The physical and mental fragility of the elderly combined with abuse is a significant cause of severe chronic morbidity and death (Lachs & Pillemer, 2015). In the view of many scholars, modern Western society still does not understand the actual magnitude of the expected consequences of violence against elderly people in the future. A drastic change in values and social morality can be dramatic and create difficult social developments, along with rising costs of the global healthcare system for daily medical treatment of the elderly (Ruelas-Gonzalez, et al., 2016).

Other researchers elaborate on the claim, suggesting that physical violence increases the chances of trauma and death. The annual medical cost due to violence against the elderly is estimated at around $ 5.3 billion in the United States, but in reality, the expenditure is much higher. Underestimation of spending is due to a significant non-reporting of violence against the elderly, patients with dementia, and other mental illnesses (Rosen, et al., 2016; Yunus, et al., 2017).

However, it is possible to take action to eradicate the phenomenon of violence against elderly people. First, the physician must visit the patient in any case of suspicion of abuse. A worsening of a chronic illness or the emergence of a new acute disease, mainly mental, may be manifestations of violence against the elderly patient. Inadequate adherence to regular medication, weight loss without a medical reason, multiple ER visits, and other factors may indicate victims of violence. One of the main recommendations for identifying this phenomenon is the separation of the elderly patient and the suspected abuser. The main difficulty for a doctor in determining an abused elderly person is a visitation accompanied by a caregiver, who in most cases is the source of abuse. Therefore, treatment of abuse when suspected by the doctor is supposed to take place without the presence of the caregiver. Thus, the central role in identifying the phenomenon is placed on the shoulders of doctors who perform regular follow-ups and know the elderly patients (Lachs & Pillemer, 2015).

Moreover, a study presenting two cases of violence against seniors suffering from dementia underscores the importance of the role of the radiologist (X-ray), who is the first clinician to examine the elderly in the Department of Emergency Medicine. Using x-rays of an injured elderly person and a specialist analysis can prove the violence of caregivers, despite their refusal to admit it (Wong, et al., 2017). Identifying violence, as well as dealing with the physical consequences for an elderly person, are crucial steps in the continuum of treatment for the elderly person. Indeed, it is no less critical for the doctor to identify not only the effects of abuse but also to remove the violent factors from the natural environment of the elderly. That is to say, any case in which suspicion was raised requires intervention on its merits. For example, when an offending therapist suffers from mental illness, he must be removed from the care for the elderly to receive proper treatment for his illness (Lachs & Pillemer, 2015). Additionally, researchers who focus on abuse recommend that a therapist is separated from the patient, at least until a conclusion regarding the source of injury to the elderly person has been reached (Rosen, et al., 2016).

At the same time, even if there is a suspicion of violence against an elderly person which is proven by objective tests such as X-rays, an emergency department cannot intervene in these cases. The lack of a clear policy for intervening in incidents of violence, and the lack of sufficient solutions to remove an elderly person from an abusive factor, leaves doctors helpless in dealing with violence against the elderly. Therefore, even when the abuse has physical signs (such as fractures and bruises), doctors do nothing with the findings. Developing the right tools and policies for intervention will help to achieve a delicate balance between proof of violence and taking necessary actions to address consequences without wrongful accusations. Also, a high level of sensitivity is required while taking the right steps regarding the treatment of abused and abusers, and this will contribute to reducing the phenomenon in the future (Wong, et al., 2017).

Effective intervention in cases of violence against the elderly is not the responsibility of the physician alone. A multi-disciplinary team can be a useful tool for dealing with the problem of violence. The correct composition of the team is doctors, social workers and lawyers, led by a nurse or a social worker. A multi-disciplinary team is a necessary basis for dealing with complex and inconclusive cases, especially when any decision made in the process will lead to a sharp change in the life of an elderly person (Lachs & Pillemer, 2015). In the case of violence against elderly people, however, the identification of the phenomenon and the operation of a multi-disciplinary team may be insufficient. According to the findings of work conducted by the Department of Emergency Medicine, in most cases, even when physical violence was identified, the elderly who were victims of violence were returned after treatment to the same violent caregiver who caused the damage (Rosen, et al., 2016). For example, hospitalization may be necessary for the removal of the abuser, even if there is no clinical need for it (Hoover & Polson, 2014).

In the view of Wharton & Ford (2014), to reduce the incidence of violence against the elderly, first of all, resources must be invested in the training of therapists. Training that is deliberately built for the care of the elderly may prepare caregivers to face the challenges of the care of the elderly. For example, a caregiver's effective and professional coping with the aggressive behavior of a dementia patient prevents physical injury to the therapist and the patient himself. Hoover and Polson (2014) support this claim. Their work shows that more than 80% of physicians have not been trained to identify and treat cases of violence against the elderly. Also, many of the physicians asked in the study believed that early identification of violence and neglect among the elderly contributes to the reduction of severe health consequences and increases the quality of care for this population group. Although many researchers believe that training programs for formal therapists are a separate solution, they will not help in dealing effectively with violence. Building a socially-based and evidence-based strategy will lead to effective interventions against violence. Thus, strategy-building, as well as policy formulation against elder abuse, is possible only after concluding the results of many controlled studies on the subject (Dong, et al., 2014). Also, Hoover and Polson (2014) believe that alongside conducting studies, a broad training base should be established between formal and informal caregivers. Training relationships between different caregivers help build cooperation for the elderly and improve the identification and prevention of violence against the elderly (Hoover & Polson, 2014).

Teaster et al. (2016) argue that when it comes to formal caregivers, they should be appropriately selected. In other words, careful screening of caregivers by selecting appropriate people and their professional training will help to prevent abuse of the elderly almost entirely. But today, even though a democratic society is committed to protecting its citizens while preserving the maximum possible freedom of a citizen, violence against the elderly continues without the intervention of any official. Prevention of violence against the elderly is based on the principles of promoting public health to reduce and prevent the phenomenon as a whole. This is a complicated process requiring the intervention of the entire society. First, and for primary prevention, a legal basis must be established by legislation aimed at preventing violence against the elderly that would allow legal protection for victims (Alon & Berg-Warman, 2014; Melchiorre, et al., 2017). At the same time, public awareness must be developed to express and educate the public to identify the problem and to report suspicions of violence. In the second stage, screening programs should be constructed to recognize violence among the at-risk population, such as the elderly (Alon & Berg-Warman, 2014). Training programs should be implemented to improve the skills of therapists to identify violence and intervention programs to deal with cases of reported violence. And at the last stage of dealing with violence against the elderly at the social level, factors that exacerbate violence that have been created in the past must be dealt with in a specific manner, such as the social and cultural isolation of the elderly and the absence of social networks for support (Alon & Berg-Warman, 2014; Wang, et al., 2015).

In Poland, from research carried out among caregivers (police officers, social workers, nurses and students) about 40% of respondents were exposed to events from a range of cases of violence against the elderly. Among the police officers, the percentage who dealt with violence of any type reached 75%. As with the other research studies, reporting is at a lower incidence (Formosa & Mackowicz, 2019).

The elderly above the age of eighty experience violence of any kind three times more than other age groups. In addition, the phenomenon of violence at this age is dangerous not only because of the high rate among the elderly but also because only a small proportion of violent acts against this social group are visible and can be proven. Furthermore, there are many superstitions in society regarding the elderly that end up minimizing the significance of the violence and hiding it behind a widespread belief that older people just like to complain, that they want to draw attention to themselves by complaining, or (even more extreme) that reporting violence, especially the violence of the people close to the elderly person, is a sign of some kind of mental disorder in the elderly person. In such a case, the value of the sanctity of the family reinforces the belief that the elderly person is inventing situations of violence by his relatives (Hoover & Polson, 2014).

Identification of violence and early treatment by correct intervention programs is the duty and professional-moral responsibility of caregivers. Thus, the construction of appropriate treatment tools to reduce violence against the elderly is their central role in the treatment of this population group (Hoover & Polson, 2014). Data from research in Canada show that in about 35% of all cases, elderly abuse stopped immediately with exposure of abuse and intervention by the authorities, which included protection of victims and practical solutions (Alon & Berg-Warman, 2014). But in reality, in most cases, interventions to eradicate the phenomenon of violence in the elderly are not only random, but their effectiveness is highly questionable (Hoover & Polson, 2014; Pillemer, et al., 2016).

Violence against the elderly has become a social problem in Israel in recent years. About 19% of the elderly complained about neglect, about 18% reported being used in some way by their caregivers at least once in the year preceding the study, about 8% experienced verbal abuse or emotional abuse, about 7% fell victim to economic manipulation, about 3% were incarcerated by their caregivers, or their freedom was limited or held for a large number of hours, and approximately 2% were physically and/or sexually assaulted (Alon & Berg-Warman, 2014). In 2013, the elderly (aged 65 and over) in Israel comprised approximately 11% of Israel's population, 849,300 elderly people. In other words, tens of thousands of elderly people suffer daily from violence in Israel as well (Shahak, 2015).

To deal with the phenomenon of violence against the elderly in Israeli society, some laws have been passed. Some are designed to combat the problem of violence against the elderly directly, while the second set of laws indirectly helps to achieve the same goal. Direct laws: legal ability and guardianship (Legal Capacity and Guardianship Act, 1962) has the function of protecting the individual who is unable, due to mental or physical illness, or vague recognition, to take care of his needs. The role of the state is to appoint a guardian who will take care of the individual's needs. When there is evidence that family members do not fulfill their duties, the court must appoint an official state guardian. The Helplessness Protection Act (1966), which allows a welfare worker to intervene if there is medical or mental neglect of a helpless elderly. A court may intervene in this situation to ensure the mental and physical well-being of a helpless elderly person, and even transfer him to another institution. Another Direct Law on the Treatment of Violence (Penal Act, 1989, 26th Amendment, Injury to Helpless Persons) is intended to draw public attention to the problem of violence against the elderly and to stress the duty of every citizen to report in cases of suspicion of abuse or exploitation of the helpless. To the extent that despite reasonable concerns the caregiver avoids reporting a suspicion, he will be detained for three months. Additionally, according to an amendment to this law, professional caregivers who care for the elderly, such as doctors, nurses, vacationers, administrators and staff of institutions for seniors, shall be punished by up to six months in case of lack of reporting. The Direct Act Against Elder Abuse: Prevention of Domestic Violence, 1991 protects the general population, including the elderly, as well as persons close to or familiar with the relationship with the victims, such as spouses, children, neighbors, friends, etc. Also, the law includes caregivers close to the elderly and the staff responsible for caring for the elderly in the institution. Another set of laws is indirectly designed to prevent violence against the elderly.

The Residential Institutions Supervision Act (1965) does not relate specifically to the elderly though it is supposed to regulate activity in institutions, including institutions for seniors. Another bill, the People's Health Regulations (1975), states that doctors and nurses suspected of violence are required to report to the police if they arrive at hospital except in a state of unconsciousness or death. The role of Guidelines for the Elderly, Victims of Abuse, 2003 (Guideline for the Care of Elderly Abuse Victims) is to increase the attention of caregivers to exploitation and violence against residents of institutions and encourage them to report any reasonable suspicion to the authorities. The law does not specifically distinguish the elderly as potential victims (Ben Natan & Tabak, 2013; Ayalon, 2014). Similar to Israel, there are laws in the US, Canada and England, which oblige caregivers to report any suspected abuse to the authorities and to allow maximum protection for helpless elderly people in distress, such as an English position statement based on six principles: empowerment-presumption of person-led decisions and informed consent, prevention, proportionality-proportionate and least intrusive response appropriate to the risk presented, protection-support and representation for those in greatest need, partnership through services working with their communities and accountability and transparency in delivery of safeguarding. (Wang, et al., 2015).

Building formal laws that create legal protection against violence is an important issue, but not sufficient in itself. An increase in the rate of the phenomenon of social violence against the elderly requires, first, the provision of psychological assistance to the victims to build the inner strength to deal with the phenomenon in the elderly person’s environment. At the same time, it must be remembered that the human world does not exist without violence. Violent behavior characterizes every field of human activity – professional, familial, and social. This is due to the nature of human societies that are built on conflicts against the background of different desires, interpersonal conflicts over control, and individualistic aspirations that accompany a person in his development. For a person in society, violent behavior is a way to achieve certain desires and goals and is a means to build desirable living conditions. Therefore, before building formal laws on the matter, it is extremely important to internalize and implement existing social norms, while respecting the general laws of nature, such as mutual respect and the prohibition of harm and use of force towards other people and other living beings. Respecting these rights begins with the individual’s personal choice– not to harm the weak. This is especially important in the case of the elderly, whose physical and social condition lead them to withdrawal, resignation and anxiety, although they have the full right to enjoy all the benefits of social life, like everyone else in society (Luszczynska, 2021).

Despite the presence of legislation in favor of protecting the elderly from exploitation and violence, their enforcement is deficient. Thus, the phenomenon of violence against the elderly is growing and arouses great public interest, but remains without proper treatment (Ben Natan & Tabak, 2013; Ayalon, 2014).

Ariela Sternbach, in her article to the press, "Cousins and Elderly Makers: A Disturbing Horror in Nursing Homes." (2017), raises the public debate in Israel about the abuse of elderly people in institutions for the elderly. According to her, almost everywhere in Israel there is a harsh attitude to residents of institutions, elderly people of different ages. Ariella documents the phenomenon of the elderly in various institutions who complain of neglect, abuse, exploitation and violence daily. In response to this article, a senior official at one of the institutions for the elderly admitted that even when she knew about the therapists' violent behavior, she could not fire them. This is due to the severe shortage of manpower; it is necessary to turn a blind eye to violent incidents that take place daily. Further, elderly home workers are afraid to report cases of violence, even if they have witnessed them, because of the possibility of losing their livelihood. The Ministry of Health said in response to this report that the Geriatrics Department and the Ministry of Health publish from time-to-time procedures and guidelines that require the institutions to act accordingly, including the subject of mechanical and chemical restrictions. Caregivers are committed to maintaining patient autonomy and preventing violence. In addition, under the Supervision of Nursing Institutions Law, controls are made regarding the restrictions and rights of patients. Also, contrary to the opinion of the director of the institution, according to the inspections carried out by the Ministry of Health there is no significant lack of manpower. Moreover, in response to this article, Minister of Labor and Welfare Haim Katz sees with great severity the suffering of the elderly caused by therapists. Additionally, his office regularly checks to ensure that institutions meet the requirements and conditions of the license and standards established by law. However, journalist Ariela Sternbach reveals a different reality. According to her, cases of abuse of the elderly are on the rise, and the Welfare Ministry does not meet the requirements of supervising the institutions. Only in isolated instances of violence are indictments filed and there is no way to prevent an abusive worker from continuing to work with the elderly (Sternbach, 2017).

Rotem Elizra and Itai Blumenthal (2017) reveal a similar reality in their article "Because of Suspicion of Abuse Caused by Death: order to Close New Hospital Admissions." An elderly man in an old-age home in Or Yehuda is suspected of having fallen victim to a physical assault and died. In light of this, the Ministry of Health issued a closure order to the nursing home, and the abuser was arrested. A newspaper investigation revealed that two days before the elderly man died, the Ministry of Health was informed of the exceptional incident involving the elderly. It was only two days after the event that the elderly man was hospitalized. The elderly man testified before police officers who came to collect his testimony at the hospital about the abuse he suffered at the institution. In response to the incident, senior members of the nursing home claimed that they were cooperating with the authorities and that there had been no complaints about the staff to that point (Elyzra & Blumenthal, 2017).

In his article "On the body, were found suffocating marks." Janowski (Janowski, 2017) touches upon the grim reality that therapists are not in a hurry to report incidents of violence that they witness. A 90-year-old man was found dead in his bed with suffocation marks on his neck, and several elderly people showed signs of bruising on their body during the same caretaker's shift. Many staff members testified to violent acts by the same abuser, only after an investigation into the murder of an elderly man of 90 (Janowski, 2017).

The experience of violence, regardless of the type of injury, brings into the life of the elderly person and his family a tremendous mental strain that significantly harms the quality of life and health and constitutes a broad public problem. Despite high costs and the burden on health systems, rapid, understandable and active intervention to deal with the phenomenon of violence against elderly people is necessary. Meanwhile, violence in modern Western society continues to claim victims and bring about many social consequences (Formosa & Mackowicz, 2019).

It is important to note favorably the various policymakers in modern Western society who in creating laws shift from the traditional view of the elderly as poor, incapable, fragile and unable to be employed. Instead, they adopt a more modern, positive outlook on human aging. It is reasonable to assume that the variety of new laws legislated in Western countries based on a better attitude towards the elderly will change society's view of the elderly for the better, by creating values that will strengthen a positive attitude towards both aging and the elderly (Formosa & Mackowicz, 2019).

The starting point for a variety of systemic changes is a change in the social stereotype regarding aging and the elderly. Social campaigns must be organized against all forms of discrimination and violence against the elderly – not only physical, but also emotional, financial, and sexual. There is a need for social education and changes in social consciousness that can be introduced by building an intergenerational dialogue, reducing the scope of economic exclusion, improving the accessibility of the elderly to care, nursing, health and rehabilitation services, involving the elderly in all types of social initiatives, and giving them the feeling that they are still part of the social stream of life (Yon, et al., 2017).

4.8. Ending life: Advanced care planning, euthanasia, and suicide in the elderly.

In the discussion on the determination of end-of-life plans and the mapping of the expectations among the elderly, it is important to begin with the mapping of life expectancy in modern society. What is modern life expectancy? What is the known maximum longevity of people in modern Western society? Because of innovative technologies and the improvement of living conditions, modern medicine has learned to extend the life span, but it has not yet succeeded in extending the body's physiological functioning without limitation. Thus, despite the aging of the population that characterizes the modern Western population, it is customary to think that life expectancy is restricted by the physiological ability of the body itself, even when this is healthy aging without chronic illnesses. However, some gerontologists hold that although the maximal lifestyle set in modern Western society is 115 years, there is a certain flexibility. The oldest age reported at death continues to rise moderately. Thus, for instance, in 2017 the death of a woman (Emma Martina Luigia Morano) born on

November 29, 1899, on April 15, 2017, was reported: she lived 117 years and 137 days and was considered to be the oldest woman in the world. However, the highest longevity reported is 122 years (Jeanne Calment, 1875-1997). These examples constitute proof that human longevity is not fixed at a certain age and depends on the elderly person's individual physical and physiological potential. Therefore, people's longevity has a high potential to lengthen in the future (Gavrilov, et al., 2017). Other scientists maintain that while there is a clear trend of rises in the maximum age of death, it is negligible. There is a biological border for the human body, and consequently, longevity is also limited and stabilizes at a certain age. Modern medicine has not succeeded in decoding the human genome to enable the artificial extension of the person's biological functioning. The human body is programmed on a genetic level for a limited span of life that is currently immutable, despite medical technologies and medicinal interventions (Dong, et al., 2016). The biological clock and natural border of the physiological ability of the human body are not set for the person when he ages or dies. However, 3.7 billion years of human development prove that people's lives are delineated in time, with no exceptions. Diet, physical activity, optimal living conditions, use of modern medical technologies – all these and other factors contribute to the life period in terms of health but do not extend the anticipated life expectancy. Humanity works hard on its ability to attain longer survivability. As has been determined by human development, naturally the life cycle begins with birth and the period of childhood and concludes with the period of old age and death. In addition, there is a clear and proven boundary of longevity in the functioning of the human body (Olshansky, 2016). Thus, if longevity is known and demarcated by time, then the main role of modern medicine is to determine the rest of the life plan, which will be based on the quality of life in the framework of the expected life expectancy (Frances Wand, et al., 2016).

It is acceptable to think that the average life expectancy depends on many factors, including population density, urbanization, social capital, the level of development in a particular country, the quality of the health system and its availability to residents of a particular country, living conditions and urban infrastructure (for example, air quality, access to drinking water and education), and the dominant lifestyle. At the same time, in the modern race after different technologies for prolonging youth, it is not possible to change an existing reality. In other words, it is not possible to reduce old age to a certain number of years for a given elderly person, and it is impossible to limit old age to a calendar explained by a combination of biological, psychological and social factors (Bollig, et al., 2016).

Time and length of life are measured in private life and society by death. Throughout all of human history, society has addressed the phenomenon of death with the dignity it deserves. Once this reference was God’s desire, and once it was a challenge thrown at humankind to withstand. Once it was fought using biological-medical means, and once there were religious rites to extend life and dispel death. In any event, modern humanity, like traditional humanity, has always and indisputably accepted death with humility, sadness and fear. However, the unique trait that characterizes modern culture is the attempt to dispel/defeat death. This failed attempt, which is repeatedly and stubbornly renewed, derives from modern society’s logical belief in technological innovations and social progress in human capabilities. While technology and other factors have succeeded in extending human life to a little more than eighty years, they have failed to make death disappear from human life. Nevertheless, this has only strengthened this bothersome and impossible dream and the human desire to fight death at all costs to the end, while devoting new means to it. Furthermore, medicine has succeeded in presenting a worthy front in the war with death and with great honor loses every time. About 80% of all deaths in the United States, even when the individual does not suffer from social isolation, occur in hospital and not at home among loved and dear ones. Moreover, modern society is advancing at record speed towards making death unimportant. As death becomes less important and disruptive of life, it will appear to be less frightening and painful, to be distant, and thus not important (Castells, 2010).

Building life-sustaining programs, maintaining patient autonomy, and respect for the patient's desires are the main instruments for physicians who care for the elderly, and this is their professional and moral duty. Furthermore, treatment should entail emotional therapy with a focus on the spiritual needs of the elderly such as discussion about death and future medical treatment. Caregivers must stress the message that they will not undertake life-prolonging interventions without the will of the patient, nor will they make decisions instead of the elderly to give up treatment. Additionally, the elderly expect that caregivers and family members will attempt to reach a compromise on the issues of death and rest-of-life treatment to prevent struggles among the children of the elderly and patient anxieties about life and death - especially after diminishing physical, cognitive and emotional faculties (Frances Wand, et al, 2016).

Research shows that with a lack of advanced planning for rest-of-life treatment, relatives often make decisions and act based on subjective desires rather than according to the priorities of the elderly. Therefore, discussion and planning may enable the elderly to voice their preferences regarding the future. Moreover, timely planning not only helps the elderly to map real wishes regarding medical treatments but also sets appropriate policies for achieving these goals. The process of planning the therapy helps the elderly to determine their future treatment in cases of diminished physical, cognitive and mental abilities. Collaboration between family members, caregivers and the elderly strengthens the treatment, but also allows the proper preparation of the senior for death and reduces the level of tension among family members involved in the discussion of this challenging subject. Determining the treatment plan for the remainder of life, while expressing the needs and desires of the elderly, eases the future process of decisions, and makes the treatment more moral (Bollig, et al., 2016).

Death is a natural extension of life. At the same time, the determination of the remaining life plan and the making of treatment decisions regarding the future prognosis of these diseases is not routine in the work of a physician. This disadvantage is even more evident in the treatment of dementia. For the most part, when the patient's dementia is diagnosed, neither the patient nor his family are exposed to the future prognosis of the disease. Therefore, the expectations and wishes of a patient are not discussed at all. In the progression of the disease, when there is cognitive and functional decline in a patient, the family and/or formal caregivers attempt to formulate decisions about a treatment plan for the elderly. Decision-making in favor of the patient differs for each physician and may even be the opposite. It should, however, be taken into account that caregivers are motivated by the patient's best interests. However, the patient with dementia is often not asked at any point in the treatment of the illness about future expectations, given the cognitive decline that develops as an inevitable result of dementia. It is, therefore, the duty of a formal caregiver to initiate a discussion by asking questions regarding rest-of-life treatment, to obtain answers from the patient, document them, and update relatives if there are changes in the caregivers' decisions (Kouwenhoven, et al., 2015).

Alongside the naturalness of death, its perception as a clear and inevitable part of the circle of life, it is necessary to take into account the elderly person’s views on this subject. For the elderly, death is one of the most difficult topics to discuss and understand. For them, death is associated with inevitable and imminent loss, which comes after many other losses experienced in their lives. Elderly people are more likely than others to lose; they lose their social roles, their relationships with acquaintances, friends, and family, and their health and fitness. Last, the elderly lose their lives too. So, death for them is a symbol of loss, while the elderly themselves symbolize death for other generations (Dierickx, et al., 2016).

The absence of a structured plan for future therapeutic preferences becomes particularly critical when the elderly are suffering from dementia. Morally, no caregiver, whether a relative or a physician, can take responsibility for decisions for another person. This is particularly true when a person is mentally incapable of deciding or expressing an opinion about his or her future in the shadow of the disease (Dening, et al., 2012).

No caregiver knows for sure the patient's explicit wishes if the patient has never uttered them or left no written instructions. Consequently, the caregiver decides for the patient based on personal experience or various interests that may prove to be utterly unrelated to the patient. Determining a future treatment plan, even if no cognitive decline is expected, should be a routine part of the treatment and physician visits. Planning treatment following the expectations and preferences of the elderly in therapy will reduce the tensions involved in decision-making among formal and informal caregivers. Advanced planning will provide an appropriate and dignified response to the wishes of the patient with cognitive decline (Dening, et al., 2012).

End-of-life plans, making decisions about desired treatments, leaving a will, and other important issues are routine daily tasks in old age. The problems often raise the subject that people try to avoid - the matter of death and the desire to die. The wish to die is common among the elderly and is perceived by many people as natural. However, attentive, empathic caregivers who do not adopt a paternalistic approach may be able to understand how this wish should be translated. In other words, does the desire stem from the negative feelings of the elderly, and is it a silent cry for help? Is the elderly patient afraid of moving to an institution? Or merely suffering because of the loss of a spouse or feeling undesirable in the family? An in-depth observation into the reality of the elderly, intelligent accompaniment, and cooperation between the elderly and caregivers (without discrimination based on age) will help the caregiver find a suitable solution to the problem that lies behind the desire to die (Frances Wand, et al., 2016). Bolling et al. (2016) support this claim, as they believe that the desire of the elderly to die is mainly due to the perception that death brings pain relief, calmness, rest and happiness (Bollig, et al., 2016).

When chronically ill patients suffer from loss of dignity and personal autonomy, then death may seem a possible way to maintain the residual dignity. Moreover, most of the elderly who participated in the cited study expressed the need for social connections (not to be socially isolated/alone), adequate pain management, and avoidance of long-term medical interventions that prolong poor life quality. However, where there is an absence of these conditions and a lack of trust in the conduct of caregivers in these aspects, the elderly express a desire to die. Accordingly, an affront to the dignity of the elderly and insufficient or insensitive treatment make the elderly want to die. Nonetheless, the elderly who participated in the study did not seek assistance in realizing their wish to die (Bollig, et al., 2016).

The idea of seeking assistance to take steps toward death is not new and occurs among people with chronic, mental and age-related illnesses. The expression of a desire to die is associated with achieving a comfortable, peaceful and calm death, without fears, anxieties and pain. In ancient Greek "euthanasia" means "good death". Natural death is characterized by peace, perfection and mental readiness, without violence. In our times, the meaning of euthanasia has several interpretations. One of them is the cessation of a person's suffering in hopeless situations when there are no other means of alleviating the condition other than death. Unfortunately, there is a problem with the definition of euthanasia in the modern literature, because of the dependence of the definition on the author's cultural background (Botseas & Drosou, 2014).

Modern medicine recognizes some types of euthanasia. Active euthanasia is an increase in the dosage of the drug by a patient himself. These are usually patients with incurable diseases that cause mental and physical suffering. Another type is active euthanasia without the informed consent of the patient. The patient may be in a deep coma or unable to understand his condition or give informed consent due to a mental state. Another type of euthanasia is passive euthanasia. In other words, the patient is connected to a machine that provides cardiac support, and without the apparatus, the patient's life is interrupted. Another sort of euthanasia, indirect, occurs when the patient is prescribed additional analgesics that may suppress breathing or cardiac activity and indirectly cause death. Finally, euthanasia may serve as a measure of actions that help another person commit suicide, such as providing medicines, means, knowledge and physical assistance (Botseas & Drosou, 2014; Rezende, et al., 2014).

In 2002 Belgium approved legal euthanasia within its borders and was later joined by Switzerland, the Netherlands, Luxembourg, Colombia, and five states of the United States (Washington, Oregon, California, Vermont, and Montana). Most countries that approve euthanasia demand the following conditions: A patient's willingness to die; full cognitive ability; complete knowledge of one's health and medical condition; and lack of treatment options. When a patient fulfills all the requirements, the patient must consult with three independent specialists to enable supervision and evaluation of cases by a government committee regarding euthanasia performed within its borders (Dierickx, et al., 2016).

The rate of applications for euthanasia has increased significantly since 2002 when the euthanasia law came into force in Belgium. Moreover, among reported requests for medical assistance for the cessation of life, the proportion of adults over age 80 is particularly prominent. Thus, the ratio of elderly seeking euthanasia medical assistance over the age of 80 who live in retirement homes and do not have cancer or other terminal illnesses increased from 1.9 percent in 2007 to 4.6 percent in 2013 and continues to rise, following an increase in the elderly population in Western society. It should be noted that the rate of euthanasia applications among the population under the age of 80 increased from 33.9% in 2003 to 39.3% in 2013. As with the increase in euthanasia among the population over the age of 80, the rate of applications from a population under the age of 80 is also expected to rise (Dierickx, et al., 2016). Canadian research has shown that the number of Canadian citizens who turn to the Netherlands for euthanasia/suicide with medical assistance has increased significantly and will continue to rise in the future. While comprehensive data is still lacking, it can be estimated that between 1% and 4% of all Canadian citizens who traveled to the Netherlands between 1990 and 2013 did so for the purpose of ending their lives. Like other data collected in the Netherlands, about 20% of the patients are over the age of 80. About 20% of them are not suffering from cancer. Also, 40% of the total number of patients who applied for medically assisted suicide shortened their lives by one week according to their medical prognosis, and about 60% shortened their lives by a month (Trachtenberg & Manns, 2017). Van Wijngaarden et al. (2015) found that the proportion of elderly who did not suffer from chronic or malignant diseases but reported extreme fatigue from life increased from 31% in 2001 to 45% in 2008. The data is similar in other countries in Western society, although the formal policy used in these countries regarding suicide assistance or euthanasia is substantially different. For example, in the United States, medical aid for suicide is legal, while euthanasia is still illegal. In Holland, Switzerland, Belgium and Luxembourg, assistance and euthanasia are followed according to some stringent conditions. The increase in requests for assistance in suicide, the lack of mutual policy, and a large variety in rules for medical assistance for suicide and euthanasia - provoke intense public controversy (Dierickx, et al., 2016). Consequently, as early as 2015, another 18 US states expressed their desire to authorize medical assistance in suicide and join other countries that allow medical assistance in death and other states that allow euthanasia. According to researchers, the increase in death requests, as well as the number of physicians willing to actively assist, and the increased number of countries willing to allow medical assistance to commit suicide are signs of a moral decline in modern Western society (Ben Mitchell, 2015).

Other researchers oppose this claim. The aging of the population in Western society, increased numbers of elderly, lack of adequate health services for seniors, dementia, the economic burden on family members, and many other factors require formal and informal caregivers to create a clear and uniform policy for regulating and supervising matters related to euthanasia. It is imperative to understand that when looking at the suffering which results from dementia; a family caregiver must cope with a tremendous emotional burden. Thus, the caregiver feels guilt and failure due to not being able to afford high-quality treatment. On the other hand, even when it comes to euthanasia, the process is accompanied by the same emotions that grow when there is no absolute certainty about the wishes of the patient (Dening, et al., 2012).

In Denmark, for example, to prevent the abuse of euthanasia and medical assistance for suicide, and to limit the rate of patients who express the wish to terminate life, six necessary conditions must be fulfilled: the physician must be convinced that a patient's decision to end their life was well considered and accepted without pressure from another person. Additionally, the physician must know unquestionably that the patient's suffering cannot be alleviated or cured. The physician must inform the patient of all the existing chances regarding the development of the disease. Furthermore, both the physician and the patient must be convinced that there is no other alternative to the condition of the patient apart from the cessation of life. When the four requirements are fulfilled, the patient will consult with another uninvolved physician. A final condition for obtaining a permit to terminate life requires that the act itself be carried out professionally while adhering to the rules of medical ethics. At the end of the process, the request for euthanasia or medical assistance to commit suicide is transferred to the deciding committee (Kouwenhoven, et al., 2015).

Active suicide is a logical act, that has been defined "as occurring when a person can reason, possess sufficient information, have a realistic worldview, and act (to end their own life) according to their essential interests" (Frances Wand, et al., 2016, p. 1). Despite the high prevalence of the desire to die and suicides among the elderly, the desire to die and think about suicide is typically a social taboo. Indeed, in Western society, under exceptional circumstances, such as terminal illness that involves great physical and mental suffering, suicide or longing for death may be perceived as understandable and even positive. When the individual reaches difficult situations without finding a suitable solution, he/she will see death/suicide as a desirable solution that promotes cessation of suffering, restores control over life, and provides a sense of independent decision-making (Rezende, et al., 2014). Alongside terminal illness, old age is a situation that is personally perceived as extreme in terms of its complexity and the lack of resources for coping.

The aging of the population in modern Western society exposes the elderly to a particularly long and painful death, without effective intervention, regardless of disease. The almost universal perception of Western culture that old age involves much mental and physical suffering encourages the elderly population to view death not only as a positive solution but as the only solution for the challenges of aging. Even in old age, there are many different reasons for the desire to die. Depression, social isolation, anxiety, lack of physical abilities and disability, dependency on others, and pain are a few (Frances Wand, et al., 2016).

Rezende and his colleagues (2014) concluded that one of the main reasons for the desire to die among the elderly population is social indifference towards the elderly population, which draws its strength from the perception that the life of old people entails suffering, illness and death. On the other hand, the desire to die, regardless of age, is not automatically translated into suicide activity. The phenomenon of suicide is not unique among the elderly. That is, the desire to die/or to end life is not always related to mental illnesses or personal characteristics. The phenomenon of suicides among the elderly is characterized by taking a rational stance and an informed choice of all options available to the elderly. It is a profound decision that stems from a social inability to take responsibility for the significant rate of suicides (Frances Wand, et al., 2016). Other authors agree with this proclamation. All patients want to receive high-quality treatment that includes personal attention and respect, especially regarding rest-of-life treatment. People are afraid of a situation in which they will not receive proper treatment and without the possibility of responding or expressing a desire to die. Therefore, the elderly may want to die because they are well aware that the rest of life in contemporary society is neither optimal nor humane, with the prospect of increased suffering for patients and their families (Dening, et al., 2012).

Researchers who have studied suicides of elderly couples claim that the desire to die expressed in euthanasia or suicide is the result of fears that characterize aging more than any other age. According to testimonies left behind after marital suicides, the elderly are more afraid of separation, dependence and loss of abilities than of death. Personal fear and experience lead older people to see death, joint suicide or mutual euthanasia as the better solution. Therefore, a common desire to die among elderly couples is a joint agreement between two adults to die together at the same time and place and thus maintain their desire to remain together and control the continuation or end of life. Sometimes, the death of old people seems to be natural or due to a mistake in taking drugs and only the family knows it was suicide by taking a high dose of existing drugs (Van Wijngaarden, et al., 2015).

Susan Sontag (1989) in her book *Aids and Its Metaphor* discussed at length the fears entailed by disease or different health situations that objectively are not defined as diseases. Sontag compares illness to an enemy faced by the patient. Even when there is weaponry, the outcome of the war is not clear to either side involved in it. Thus, even when there is a proven treatment for the disease, it jeopardizes the daily routine to which the patient is accustomed and creates a feeling of fear and anxiety about the results it will bring in both the near and distant future. Sontag explained this through the implications that the thinking itself about the illness causes the sick person. In her opinion, unending thoughts about illness harm the person’s life no less than the illness itself. In other words, a person tends to suffer from thinking about sickness more than he suffers from the disease in his everyday life. Sontag even broadened this assertion, adding that it is possible to die only from thinking that there is cancer or even to suffer from the same symptoms that are reinforced by fears and anxieties that are created in the person's thoughts about the illness regardless of the real severity of the implications on life (Sontag, 1989). Thus, elderly people who think about death because of their fears of being physically dependent on others, even when they are clear-minded and independent, suffer from the thought of old age and its results more than from old age itself.

Other researchers have stressed that not only fears and anxieties cause the elderly to want to die. Modern society has not only led to a situation in which older people cannot financially help their families but they even become an economic burden. This causes a sense of absence of self-existence, emptiness, disappearance, and not belonging. Moreover, personal loneliness and social distance are exacerbated by old age, due to an inability to properly process losses. Many older people interviewed in the study mentioned the emotional difficulties involved in coping with the death of their spouse and the failure to efficiently handle feelings of sadness associated with imminent deaths. Most seniors describe these feelings as a pain that cannot be stopped or decreased. They develop depression and a desire to die based on unresolved sadness (Machado Duran Gutierrez, et al., 2015).

On the other hand, most elderly people in the modern Western population express a desire to die but do not take any active action, instead waiting until their wish is realized. It is important to note that most seniors who wish to die do not suffer from fatal or other chronic illnesses that cause great suffering, they merely define their condition as fatigue from life. Another reason for the rise of suicidal thoughts among the elderly is their sense of rejection from within their families, which is accompanied by loss of social identity and damage to personal economic security. The elderly who participated in the study saw loneliness, lack of family affiliation, and rejection as the main reasons for their desire to die. Socially, the interaction between a senior and his family is crucial. However, even when an elderly person defines his/her relationship with his/her family as good, they are still liable to suffer from loneliness and a sense of personal futility. These feelings, as the elderly move out of their homes and their environment, expose them to a stressful experience, loss of meaning in life, and emotional emptiness (van Wijngaarden, et al., 2016).

The desire of elderly people to die, the positive meaning of death at an old age in society, the reduced value of the elderly person’s life, the decline in the importance and necessity of the elderly person to the existence of society, and many other factors are an outcome of the nature of modern Western society. The aging of the population has led to a distorted perception of the meaning of death. Thus, modern Western society ascribes different content to the death of a child as opposed to the death of an old person. Death at an advanced age is perceived more positively, and therefore it entails less grief. In contrast, the death of a child and/or a young person is accompanied by pain and bereavement and therefore is interpreted as a negative event. However, even when death is perceived as natural, as in old age, society isolates and conceals the death behind the walls of institutions such as hospitals. Hence, while distancing the death of the elderly and making this death transparent, modern society displays an almost complete willingness to sacrifice the elderly for its continuity. The isolation of the death of elderly people in hospitals and the removal of this death from the home and the family reduce the feelings of grief and sorrow and eliminate almost completely the universal meaning of death (Rzeszut, 2017).

In other words, the influences of the phenomenon of the aging of the population yield the phenomenon of "granny dumping" (Rzeszut, 2017, p. 446), which has increased in recent years. The phenomenon was given its name by nurses in hospitals, and in 1991, it was defined in the literature as the intentional abandonment of the elderly person in public places by the caregiver who had assumed the responsibility to see to the elderly person's needs and care. In holiday periods, family members bring elderly people to hospitals, for the most part without a serious health reason that necessitates referral to hospital. If there is no need for hospitalization, and it is possible to release the elderly person to his home, then the family refuses to take him home until the end of the holiday – if at all. The situation is more severe for the elderly who suffer from dementia and receive care at home. For the most part, they are disoriented in terms of time and place and do not remember the names and identities of their caregivers who brought them to the hospital. Granny dumping has become a universal phenomenon that characterizes the aging of the population in modern Western society and that is steadily broadening in scope and beginning to concern health systems in Western society. The abandonment of the elderly person is the care-giver's public declaration of the lack of ability to continue to fulfill the role of caregiver for the elderly person without financial, physical and mental assistance with caring for the elderly person daily, 24 hours a day, 7 days a week (Rzeszut, 2017).

Creating a better reality, with new meaning, can help the elderly experience a sense of usefulness and transform the wish to die into the desire to experience new things and create a new experience. Aging does not have to be accompanied by depression, severe feelings of loneliness and a desire to die. Instead, aging can be a new beginning of new experiences with activities that bring feelings of belonging and usefulness to the surroundings (Van Wijngaarden, et al., 2016). Weinberger et al. (2014) claim that the sadness and distress experienced by the elderly mainly stem from anxieties about losing physical and cognitive abilities due to chronic diseases. They are afraid of the uncertainty that obscures their future. The elderly would like to live, but without the consequences of illness and physical or cognitive incapacity that could become a burden on their families. Sadness and grief are ongoing feelings that accompany aging, but they are not depression. Fear and concern for the future lead the elderly to express their desire to die. Moreover, when a senior identifies only two alternatives, a life of pain or death, death is likely to be chosen as the alternative without suffering and is therefore better (Weinberger, et al., 2014).

According to the development theory of Erikson (1997), after the age of 50, the individual reviews and summarizes their life. They recount successes in the face of failures and review various experiences throughout life. Sadness and sorrow are natural feelings when a person examines life concerning the goals achieved and those not accomplished thus far. Therefore, it is not at all surprising when the end-of-life examination leads the elderly person to express a desire to die, sadness, anxieties about the future, and loss of interest in life. That is to say; the old person feels despair from life. According to the evolutionary theory, at the later stage of adulthood, when individuals do not accept the events in their lives, they do not feel satisfied and do not reach the sense of "ego unity". Instead, the individual is afraid of the future, afraid to live, does not accept death, does not accept life, feels that his/her life has been a failure and a missed opportunity, and sinks into despair (Erikson & Joan, 1997).

Frankl (2006) states that when a person suffers and does not find peace and mental calmness, they are in an existential void characterized by a lack of meaning and despair. From Frankl's point of view, suicide in old age or euthanasia is devoid of meaning because mental and physical suffering is an opportunity to reflect on the sense of exhaustion in the rest of life and to find meaning in this fatigue and weakness. Other researchers warn that depression among seniors may be perceived as normal by society. Therefore, many times sadness or prolonged grief develops into chronic mental illness without proper identification and treatment. Thus, the authors recommend seeing a refusal of essential medication therapy or resistance to respiratory support as passive suicide whose early signs may have been misinterpreted by caregivers (Weinberger, et al., 2014). In the opinion of Frances Wand et al. (2016), ageism, various negative stereotypes prevalent in society regarding the elderly, paternalism and growing social indifference, alongside other factors, push the elderly towards a decision to end life by way of suicide or euthanasia, as long as the decision to terminate life is in their hands (Frances Wand, et al., 2016).

So, the ageism manifests itself in all areas where the elderly are found, such as the health system (age often affects the quality of the diagnosis), when the elderly in many cases are denied tests, treatments, surgeries and rehabilitation equipment. Besides, during hospitalization the elderly encounter degrading comments about their age from healthcare workers, they have difficulty calling an ambulance, and their families have difficulty getting assistance in caring for an older adult at home. The system that is supposed to provide support does not support but sees the families of the elderly as bothersome because the system suffers from a lack of procedures for handling many medical matters (such as obtaining prescriptions) adapted to the condition of the elderly. Western society has given rise to the phenomenon that the elderly are more afraid of the life that is expected in old age than death, despite being mentally healthy. Society is unable to provide a sense of security, peace and caring for those reaching old age. Worse still, society does not take responsibility (Weinberger, et al. 2014). Furthermore, a social perception that sadness is a normal condition in old age hurts doctors' ability to diagnose suicidal tendencies at an older age. Consequently, the elderly are not asked about the symptoms of depression. Also, in the shadow of a flare-up of acute illness, for which the elderly turn to physicians, symptoms of depression do not appear to the doctor as essential and are undergone without treatment. It seems that doctors treat what they think is necessary, and do not even refer to things that make a senior want to die (Weinberger, et al., 2014).

Many researchers agree that there is an under-identification of depressive symptoms, resulting in under-reporting of seniors expressing a desire to die or commit suicide. For example, in a study conducted among the elderly Danish population, 67% of those expressing a desire to die were suffering from untreated symptoms and signs of depression. Moreover, about 20% suffered from undiagnosed clinical depression. Also, the rate of suicide among the elderly is much higher than official statistics in Western societies. Most seniors who wish to die complain of emptiness, loss of ability, a sense of loss of control, dependence on children, while only a few suffer from terminal illnesses and mental illness. The elderly suffer from an inevitable loss of health and physical function, and naturally, there is a decline in self-efficacy. Indeed, the desire to die is caused by a significant decrease in the quality of life, which is not dependent on the elderly themselves (van Wijngaarden, et al., 2015).

Medical and social observations of the desire to die in the elderly, euthanasia and suicides, are too narrow a view of a widespread phenomenon. The aging of the world population in general, and the population of Western society, in particular, have in the present era created a common socio-cultural and historical reality for the elderly. The social discussion surrounding the risk factors for suicides, illness and mental disorders does not provide an adequate explanation for the phenomenon of suicides and euthanasia of the elderly. Physical and psychological morbidity alone does not provide a basis for understanding the phenomenon. The reality is much more complicated and entails the entire population of the elderly in Western society and constitutes a basis for social conditions characterized by social and family neglect, emotional and spiritual suffering, social loneliness, and personal narratives of loss and pain among the elderly.

In other words, good health at an older age and being in an environment that is supposed to satisfy the emotional needs of the elderly do not guarantee the absence of a desire to die at an older age. Maintaining good health and moral autonomy are indeed the foundations of a life of happiness in old age. Also, based on findings of anthropological studies, a young person almost always becomes an honorable, healthy elderly person, surrounded by love and concern, abundant in wisdom to the extent that his entire life has progressed in that direction. In other words, acquiring life experience with support and help, and creating a favorable environment for the young person increases the chances of growing old with happiness, respect and love (Machado Duran Gutierrez, et al., 2015).

Other scholars call for a deeper examination of the interpretations given to physical and mental suffering. Those who view suffering as a bad thing will necessarily support medical assistance for suicide and will consider assisting in the stopping of suffering as positive. In other words, a patient suffering from a terminal illness has a fundamental right to cease suffering permanently (Ben Mitchell, 2015). Many doctors elaborate on the claim, believing that everyone has a fundamental right to decide whether to continue or stop life. The individual is responsible for his/her body, will and life. Besides, many physicians treating patients with incurable diseases claim that every patient has the right to make decisions about the future of the illness, based on the actual medical condition and possible prognosis of the disease in the future based on an honest opinion of the physician. Even when based on knowledge, the patient chooses death as a preferred alternative and the physician must respect the choice. Indeed, when society agrees to euthanasia and provides a moral basis, legal validation must be provided to prevent abuse of this possibility and to delegate responsibility for this decision (Botseas & Drosou, 2014).

Those who oppose suicide of any kind or euthanasia emphasize the guiding value of Western society and Western medicine - the value of the sanctity of life. As it is written in the Ten Commandments: "*Thou shalt not kill*!" Further, the central values of medicine require the doctor to be a protector and a guardian of life. Therefore, when authorities allow the ending of the life of the sick, even if according to their own wishes, they should turn to the executioner rather than the caregiver. According to British doctors, euthanasia is a form of murder, and euthanasia is therefore incompatible with life-saving people (Botseas & Drosou, 2014).

Furthermore, the value of the patient's right to make decisions over his/her body and life obscures the limits of the value of the sanctity of life and causes physicians to forget that autonomy as a gateway to the emotional well-being of a patient is not the absolute human good. According to etymology, the root of the word "patient" in the Latin language is "suffer". It is therefore natural that suffering harms and limits human autonomy. Contemporary medicine can limit the period of suffering through various treatments and appropriate medical interventions (Ben Mitchell, 2015). In the view of Van Wijngaarden et al. (2015), contemporary Western society has for a long time not been led by the value of the sanctity of life as a significant social value (Van Wijngaarden, et al., 2015).

With the aging of baby boomers, the ethos of neoliberal values, such as the need for self-determination, personal autonomy and individualism has become much more dominant than the value of the sanctity of life. Awareness of death in Western society combined with a desire for self-control over these processes in the individual's life will lead to an increase in the rate of euthanasia or medically assisted suicide. The face of modern Western society will change so that euthanasia will be a therapeutic alternative in the self-management of the end-of-life program. When a person makes decisions about all processes, including how to die, the person’s fundamental right to express the desire to die, and even to receive assistance in fulfilling his/her will, even if he/she does not suffer from chronic or malignant diseases that cause additional suffering, will be supported. Indeed, a society that allows individualism and the development of self-worth at almost any price must set rules and boundaries to protect its existence (van Wijngaarden, et al., 2015). Other scholars support this perspective, asserting that euthanasia should be guided by four key criteria: the patient's level of suffering despite receiving appropriate treatment, the consistency of the patient's expressed desire to die, the patient's age, and the severity of the illness in relation to available treatment options. From a Christian viewpoint, active euthanasia - defined as actions taken to intentionally shorten life - is considered a breach of divine law, an infringement of human dignity, and a transgression against the sanctity of life. However, in Brazil, there is a possibility of stopping medical interventions that may prolong life without interrupting regular treatments. It is also possible to shorten the life of a patient by increasing the dosage of a drug, with the primary goal of alleviating severe pain and thereby indirectly causing death (Rezende, et al., 2014).

According to the goals and objectives of modern medicine, effective treatment of pain is achievable and the duty of physicians regardless of the morbidity that causes the pain. There are many innovative therapies and powerful drugs that have made incurable diseases treatable. Also, there is always a chance of a diagnosis error that does not allow the doctor to cooperate and respect the patient's desire to die. Chronic or long-term illnesses are accompanied by severe mental states in patients including depression. Proper identification and treatment of depression may significantly improve a patient's feelings, despite chronic background illness. Also, when society allows euthanasia, it will always be suspected that relatives have exerted pressure on caregivers while operating with interests that are not in line with those of the patient. When a patient's wishes are influenced by extraneous considerations (family relations, unbalanced pain), or there is such a suspicion, a patient's desire to die must be treated as temporary and should be interpreted as a demand for better treatment of the patient’s illness. The willingness to die out of physical or mental pain is influenced by many psychological and spiritual factors. Patients do not want to die; they beg for proper treatment of suffering (Botseas & Drosou, 2014; Ben Mitchell, 2015). One of the worst examples is the elderly who have dementia. Research findings show that treatment for dementia patients, especially in the advanced stages of the disease, is at a very low therapeutic level and does not meet the patient's requirements. The health system in modern Western society does not provide adequate treatment for dementia patients and does not guarantee the quality of life in the rest-of-life treatment of the rest of life. Moreover, the treatment of dementia patients is often inhumane. When a single alternative to death is a life of suffering, humiliation and pain, the sharp rise in the proportion of seniors who express a desire to die or commit suicide is not at all surprising (Kouwenhoven, et al., 2015).

Rezende et al. (2014), according to their findings, warn that euthanasia or medical-assisted suicide not only leads to suspicions that relatives have different interests to patients, but will primarily cause doctors to have fewer palliative plans, give up searching for a solution other than death, and impair professionalism and integrity. It is essential to understand that the traditional role of doctors is to alleviate the suffering of patients, and when it is impossible - to be with them until their last breath with dignity. Taking an active role in the deaths of patients may harm the public's trust in doctors. The doctor is not a murderer, his/her job is to save lives (Ben Mitchell, 2015).

Despite strong professional values, such as "primum non nocere" ("Firstly, don't damage"), doctors will have to cope with conflicting social messages and binding professional ethics. According to current approaches, society has a moral responsibility to protect individual life. However, when there are increasing amounts of countries that see in certain situations euthanasia and suicide as a plausible situation, it seems that in the future, modern Western society will change the face of social morality that has been accepted until now (Weinberger, et al., 2014).

In modern times, ethical, moral and medical observations of euthanasia and suicide assistance no longer provide a complete picture. A modern Western society that exists in a reality of limited resources leads the discourse regarding euthanasia and rest-of-life treatments to an economic discussion. The aging of the population in modern Western society and an increase in the percentage of the elderly in addition to the family and personal costs of extending life, highlight the high public cost that rests as a burden on the public health system. Currently, data are under-evaluated in most countries or are missing (Rezende, et al., 2014).

According to research findings in Canada, the cost of end-of-life treatments is a significant burden on the healthcare system. For example, in Manitoba (Canada), more than 20% of the cost of health care is attributed to the treatment of patients during the six months preceding their death, although they account for about 1% of the general population. Furthermore, the cost of medical care for patients increases dramatically in the month preceding death. There is no definitive assessment of the cost of rest-of-life treatment, although records have shown that a one-time cost of tranquilizers- analgesics ranges from $25 to $326 per case. Thus, patients who wish to end their lives may significantly reduce their suffering and save a significant sum that may help other vital areas. For example, if about 80% of patients who wished to die shortened their life expectancy by one month, the health system would save on life-prolonging treatments $5.7 million. Also, if about 80% of terminally ill patients shortened their lives by a week, investment in life-prolonging therapies would drop by $ 11.3 million, or more than 30%. In the opinion of Canadian researchers, this data does not recommend sparing life-long treatment but instead invites those countries that have not yet approved euthanasia/medical suicide to offer legal and euthanasia-based medical therapy as a therapeutic alternative. Thus, enabling an informed choice of patients while responding professionally to the preferences of patients in extreme situations (Trachtenberg & Manns, 2017).

Public interest in the subject of suicide or euthanasia, treatment costs and health care costs expose physicians to an ethical and moral dilemma. According to this, the physician is caught between two values that may present contradictory objectives. On the one hand, the value of the sanctity of life requires the physician to do everything to save lives and not to take steps to stop them, regardless of the age of the patient. On the other hand, modern Western society upholds the value of autonomy at any price, according to which the physician must fulfill the wishes of the elderly under any conditions, even when it involves suicide. Pain, a worsening of the quality of life, dependence on the other - is routine. This is not enough to stop life according to the value of the sanctity of life. On the other hand, autonomy in therapy is a value that obligates the physician. Therefore, even when a senior is no longer able to make decisions or carry out them independently, the caregiver must continue to fulfill the wishes of the elderly person (Weinberger, et al., 2014).

Today, there is not enough information about the views of seniors regarding medically assisted suicide/euthanasia. Collecting and organizing data will contribute to decision-making and legislation that regulates these issues while preserving the dignity and desire of the elderly and ensuring the neutralization of foreign interests of formal and informal caregivers. Regulation of the subject according to rules will prevent damage to the trust between doctor and the elderly and maintain the professional integrity of the physician (Rezende, et al., 2014).

Before the regulation of euthanasia/medical-assisted suicide, the population in question should be addressed and described. To date, there is not enough data about the characteristics of the elderly population that wants to die. Many questions left unanswered hinder the progress toward policymaking and enforcement of end-of-life programs in general and euthanasia in particular (Van Wijngaarden, et al., 2015).

The aging of the population and the rise in the percentage of seniors also place Israeli society, like any European country, in need of seeking answers to the many questions that arise while coping with the rest-of-life aspects of the elderly. One of the issues that is causing a raging public controversy in Israel is medical assisted suicide and euthanasia. Until 2005 Israeli society never allowed active steps to end life, even when a terminal illness was reported. Israeli courts have permitted the avoidance of life-prolonging treatments in some instances, such as separation from a respirator, avoidance of dialysis, and cessation of food and fluids. These actions have been defined as passive and in some cases are protected by law. However, as a society that went through a Holocaust in which millions of Jews perished, and as a country that fights for its existence daily, the value of the sanctity of life is central to political decision-making. On the other hand, as a democratic state - the value of human autonomy and the importance of quality of life in Israel - is also significant. To find a balance between the two values, on December 6, 2005, the dying patient bill was passed. The law attempts a balance between the sanctity of life and individual autonomy, regulates social activity in this field, and establishes clear rules and conditions for its implementation (Knesset Israel, 2005).

Morally there is no difference between an act and an omission. There is no moral difference between avoiding rest-of-life medical treatment and medically assisted suicide or euthanasia. The law requires the physician to act according to the wishes of a patient, and if the patient is experiencing significant suffering and does not want his/her life extended, the physician shall refrain from any medical treatment. Even for patients who are unable to express their wishes, who do not want their lives to be prolonged and there is no cure for their illness, the physician must stop medical treatments. The dying patient law forbids any action by a medical team that intends to actively carry out a deliberate killing or any action that results in causing death, even if the caregiver acted on behalf of the patient or out of compassion and kindness. The law requires that the medical team take every possible action that will help alleviate the pain and suffering of a patient (Knesset Israel, 2005). In 2009, a precedent-setting appeal was filed with the Supreme Court over the severity of the punishment of a person who took active action (even though the person acted out of love, and compassion for his mother) and was sentenced to a year in prison by the Supreme Court, who ruled that the principle of the sanctity of life should not be deliberately taken away). However, due to the problematic and unusual circumstances, such as the suffering of the mother, the individual received a prison sentence of only one year (Rulling according to, 2009).

Justice Elyakim Rubinstein believed that the principle of the sanctity of life should be adhered to, according to which one should not deliberately take life from a person. Following a public discussion, it was decided that the law of the dying patient does not provide comprehensive answers to the issue of rest-of-life treatment. In 2013, MK Ofer Shelah submitted a bill that would allow terminally ill patients to receive suicide assistance along with a sense of control over their final days of life, when suffering culminates, without the criminal responsibility of the helper. In the eyes of the law, this may be administered by using a high dose of anesthetic pills, which are to be issued to the patient by the prescription of a physician (Gal, 2013).

This amendment to the law of the dying patient is supposed to solve the problem of terminally ill patients and many seniors who seek salvation from severe suffering involving their health. In the opinion of MK Ofer Shelah, there is no fear of a slippery slope in which every person suffering from a chronic illness who wishes to die will turn to the doctor for a lethal prescription. On the contrary, anyone who wishes to end their life due to health problems will enjoy the ability to trust that when the time comes, they may receive a dignified solution (Gal, 2013).

Ofer Shelah's bill proposal provoked outrage and opposition in Israeli society. By a majority vote, the Knesset rejected the bill in a preliminary reading that offered dying patients a prescription for anesthetic drugs. Most of the Israeli public views euthanasia as murder that does not go hand in hand with the values of doctors who are obligated to preserve life. On the other hand, a minority believes that granting permission for euthanasia/medical assistance in suicide is consistent with the Basic Law: Human Dignity and Liberty. Consequently, there will be no euthanasia in Israel (Gal, 2016). The dying patient's law does not provide a solution for people who are not dependent on life-prolonging machines or suffer from terminal diseases. Elderly people suffer from physical and mental problems that are not defined in the law that allows physicians not to take invasive actions to prolong life. Legislators do not allow the elderly to end their lives humanely and condemn them to a life full of pain and suffering or suicide (Gal, 2016).

Moreover, rejecting the euthanasia bill prevents seniors from ending their lives whenever they choose and with the dignity they deserve, instead continuing their and their families' suffering. The absence of a legal solution for those in Israel who seek assistance in suicide/euthanasia has led Israelis to search outside the borders of the state. Thus, in recent years, Switzerland has become a euthanasia center for many foreign citizens, including economically advantaged Israelis. Swiss law (Article 115) allows the activities of various organizations that help to obtain euthanasia for payment.

One of the best-known organizations is the Dignitas Organization, in which Adi Talmor, an IDF broadcaster, ended his life in 2011. Adi Talmor's death has sparked many debates in many public sectors and increased awareness of a painful and controversial issue in Israeli society. Adi Talmor was not the first Israeli to receive Dignitas' services. However, there is no accurate and accessible data regarding the rate of Israeli citizens who turn to Switzerland for medical assistance to die with dignity. Despite numerous attempts by Israeli journalists to obtain information about Israelis who have used the organization's services, the organization maintains the confidentiality of these individuals. The organization ensures that all patients receive attention, and moral and legal accompaniment when choosing euthanasia as an alternative to a suffering life, as well as strict confidentiality and privacy in the process itself (Grossman, 2011).

In parallel to public discussions concerning allowing doctors to help with the suicide of terminally ill patients, the Ministry of Health reports a significant increase in the rate of suicides among elderly people aged 75 and older who do not suffer from terminal illnesses. It has been suggested that one of the possible causes of this is that this generation is simultaneously taking care of their children and their 90-year-old parents. Longer life expectancy leads to additional problems for which solutions have not been found in Israel (Rosenberg, 2017). Among them: How will rest-of-life treatment be for healthy and sick elderly people? Will society be able to provide proper and dignified treatment for elderly people with advanced dementia, even though their numbers are increasing with the aging of the population? Furthermore, a discussion of euthanasia or suicide in Israel is not complete without emphasizing the religious aspect. Israeli society, especially when it comes to decisions on a political level, is strongly influenced by religion. Therefore, religious eccentricities often guide legislation and decisions on moral and ethical issues (Steinberg, 2003).

In the opinion of Abraham Steinberg, who based this on the most significant halachic authorities on the establishment of the dying patient law, the value of the sanctity of life is considerable, but not an absolute value in the Jewish religion. Other values exceed this value according to Jewish law, and these are going to war or death for the sanctification of God. According to Jewish law, it is forbidden to take active action, such as assisting in suicide. Therefore, whoever takes active action is a murderer, even if done with compassion and love for the suffering person (Steinberg, 2003).

Moreover, if it is possible to extend the patient's life for even an hour, it is necessary to do so, even when life expectancy is short, the patient is suffering considerably and even when the patient is opposing life extension. Moreover, concerning the autonomy and right of a patient over his/her body, according to Jewish law, a person does not own his/her body entirely and has, therefore, no right to harm his/her own body, or others even upon the explicit request of the patient. However, there are situations of such severe anguish, which give an individual an autonomous right to refrain from life-prolonging treatment. Further, if the patient cannot be cured of the illness through the existing therapy and can only prolong life in agony, the patient should be asked whether he/she is interested in a life of suffering through treatment for extending life. But if the patient understands the status of the illness and expresses no interest in living a life of suffering - one should not prolong the life of the patient against their will. However, once a life-prolonging treatment begins, it should be terminated even if the patient regrets their consent. Furthermore, according to rabbis, even when the patient is defined as a terminal patient, procedures that began before the diagnosis should continue. Since eating is natural and necessary, the provision of food and liquids should continue even when a person is defined as dying. Those who prevent the feeding of the patient may be considered murderers. If patients refuse to eat, they must be told about the significance of food for life. However, if patients continue to decline to eat – they should not be forced (Steinberg, 2003).

However, when patients are unable to express their own opinion on the subject, they should be fed through a tube. The same rule applies to oxygen connection through non-invasive means. The caregiver must continue providing oxygen. On the other hand, when a caregiver feels that the non-invasive oxygen supply is no longer adequate, but a connection to a respirator (invasive device) will prolong life - the caregiver may avoid intrusive breathing (Steinberg, 2003). Some doctors do not wholeheartedly agree with the Jewish law. In the opinion of Dr. Daniel Daliot, a Geriatrician, severe suffering is unacceptable in an enlightened and progressive society. If a patient has concluded that death is the only alternative or has expressed an opinion on the matter before a decline in mental ability, the physician must assist the patient. Physicians should treat and support patients throughout life, including death. Therefore, avoiding treatment that prolongs unnecessary suffering and helping to reach a dignified death is a high professional value for physicians in the modern era, just like life-saving medical care (Ben Dov, 2014).

According to Grosssman (2011), in every case, the caregiver's role is to allow the elderly to conduct their dialogue with death. This is by talking about what he feels, experiences, or is afraid of and also about what he regrets in his life. Such a dialogue is not only a criticism of his life; it is also a means of reviewing different experiences throughout his life and remembering them in the way he wants. Accompaniment, support and help around death consist of meeting all the needs of the patient in areas such as general physical care, treatment and relief of pain, and providing emotional, psychological and spiritual support. It is important to realize that help in understanding what death is for everyone, but especially for the elderly person, is a great gift that helps patients to come to terms with death (Grossman, 2011).

This chapter summarizes how modern Western societies are shaped by a rich heritage: Greek and Roman thought, Christianization, and advancements in science and technology. This chapter delves into their unique characteristics, particularly their emphasis on fluidity and individualism, and touches on various topics, as discussed in A World in Flux: Challenging the Past (Giddens 1991-2000, Bauman 1998-2004). According to the authors, modernity is characterized by rapid change and uncertainty. Unlike the stability of the past, it disrupts predictability. Technology, while offering progress, introduces new complexities and risks. Castells (2010) acknowledges its benefits but emphasizes the need for adaptation. Another topic in the chapter is how emotions take center stage (Illouz, 2007). Thus, modernity is driven by emotions, influencing personal choices and societal interactions, moving from solid to liquid: a shift of modernity (Bauman, 2004). Traditional, "solid" modernity emphasized order and clear social structures. In contrast, "liquid" modernity is characterized by fluidity, impermanence, and a lack of rigid frameworks.

Another topic is the rise of the mobile elite and the erosion of trust. New power structures emerge with a mobile, global elite controlling resources and technology, while the majority experiences a sense of detachment. Public trust in institutions and leadership weakens due to perceived failures and lack of transparency. Also, there is the phenomenon of the individualized self. Modernity emphasizes individual responsibility and self-creation. People navigate a complex world, constructing their own identities and meanings. This individualized freedom offers choice and critique, but it can also lead to a sense of isolation and a lack of solidarity in addressing social issues (Beck 1992, Bauman 1998-2004, Castells 2010).

Jobs are becoming more temporary and knowledge-based, requiring constant adaptation and flexibility. Disagreements exist on the impact of this change, with some seeing it as liberating (Castells, 2010) and others as creating insecurity (Beck 1992, Bauman 1998-2004). There also exists the enduring power of social interaction (Mead 1973, Cooley 1992). Despite the emphasis on individualization, social interaction remains crucial for shaping identity and self-understanding. We learn to see ourselves through the eyes of others, internalizing societal norms and values.

This chapter paints a complex picture of modern Western societies. While technology, freedom and individual choice abound, these advancements come with challenges like uncertainty, social isolation and power imbalances. Modern Western societies are a fascinating work in progress, constantly evolving and grappling with the consequences of change.

5. Methodology of research:

5.1. Research question and hypothesis:

This study aims to explore caregivers' perspectives on the quality of care provided to elderly individuals with dementia.

The primary question this study seeks to address is: what are the attitudes of different caregivers (such as nurses, physicians and caregivers in the home and old age homes) regarding the quality of care given to dementia patients at the end of their lives in old age institutions and hospital departments in Israel?

There is a feeling that there is a great variety of attitudes among different caregivers regarding the quality of care and performance of invasive activities that do not improve the quality of life and do not extend the lives of elderly dementia patients at the end of their lives. For instance, nurses in hospitals will tend to hold negative attitudes on this matter, while nurses and caregivers in old age homes will tend to hold positive attitudes. In addition, nurses and physicians in medical centers will tend to evaluate the quality of life of elderly dementia patients at the end of their lives as significantly lower than that of other patients in a similar situation.

5.2. Researching models:

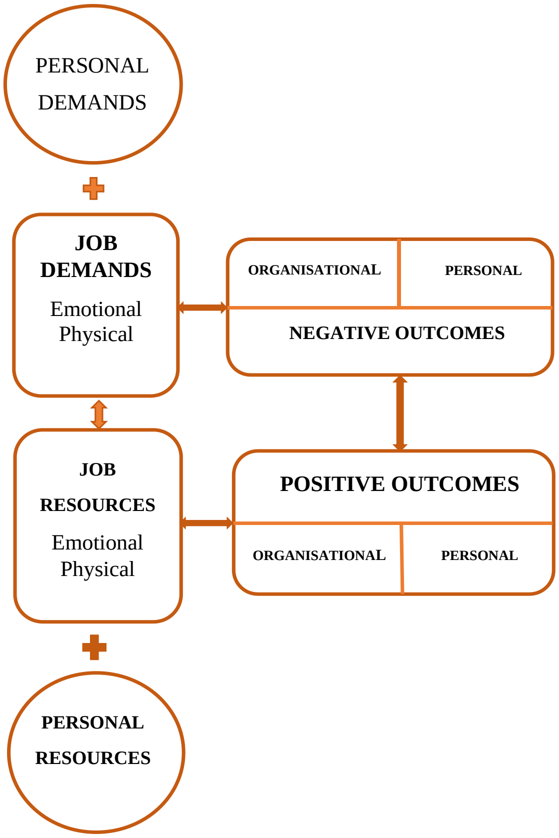
5.2.1. The Job Demand-Resources Model of Karasek:

Reciprocal relationships in society require considerable skills, investment, consistency, and perseverance from every participant. Help, support or care for a person who is sick or in a difficult health situation confronts the caregiver with a meaningful emotional and physical challenge in terms of human abilities. Conversely, the care of a sick person may be fulfilling and empowering for the caregiver. For example, when a patient recovers following the caregiver’s efforts, the caregiver feels tremendous satisfaction from his work. The daily reality is not always optimistic. In actuality, when caregivers deal with a terminal patient and/or a difficult health situation, the final health outcome is not known or is not commensurate with the desires of the patient or family members. The caregiver’s coping with patients in difficult situations of illness entails high demands. To deal effectively with the demands of the role, the caregiver needs a store of vital resources, such as, for example, emotional support. The achievement of balance between the demands for resources leads to good outcomes. However, the disruption of the balance causes negative outcomes (Karasek, 1979).

According to this model, tension and harm to the mental well-being that these nurses feel are the results of a lack of balance between the demands and needs that the role/workplace sets and the psychological, social and physical resources at the nurses' disposal. According to this model, there is a negative correlation between the high demands of the role of the caregiver, in combination with the low support and esteem in the workplace, and the caregivers' mental well-being (Willemse, et al., 2014). The caregiver's role is known to include mentally and physically challenging situations. When the workplace does not allow appreciation and emotional support for their workers, they will tend to leave. In contrast, when a worker enjoys social support and appreciation in the workplace, the percentage of workers who leave the workplace drops significantly. In other words, the work environment of nurses is of decisive significance to their mental well-being. Consequently, tension during the caregiver's activity is related not only to the nature of the department but also to the nature of the work environment in which the care session of the caregiver and the patient occurs (Tripodi, et al., 2012).

According to this model, people tend to want to achieve reciprocity in all fields, including the health-medical field. When the requirements of the role exceed the resources invested in the situation over time, the caregiver will feel a lack of fairness, which will develop into a feeling of tension in similar situations. For the achievement of balance in situations of tension, the caregiver will look for diverse resources that will help him in this. When the recruitment of the resources has failed, the caregiver will develop burnout – as an initial product of situations of tension in the reciprocal social relationships (Bakker, et al., 2000).

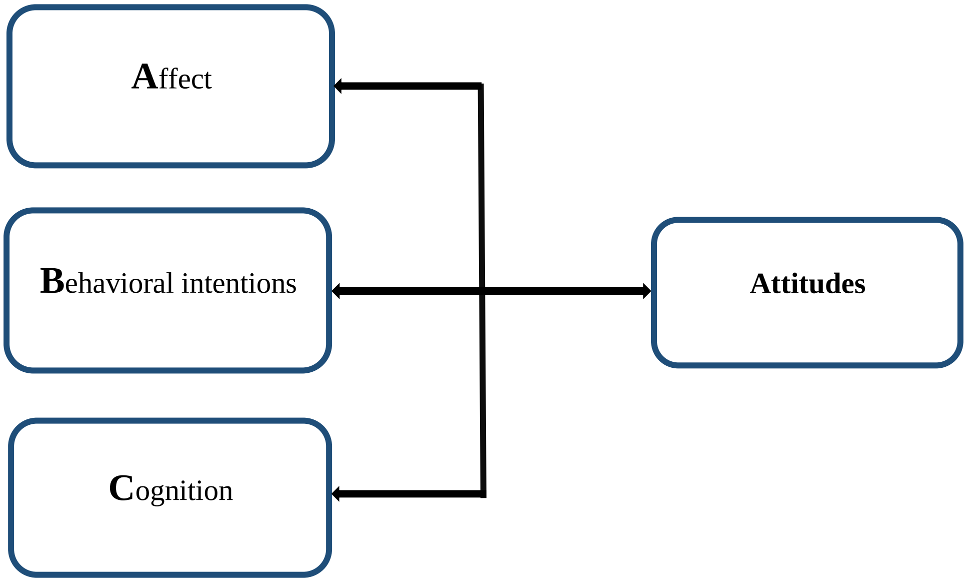
Figure 14: The Job Demand-Resources Model of Karasek (Karasek, 1979).



5.2.2. The ABC Model of Attitudes:

Another model that may help in the characterization of the attitudes and the finding of explanations of the attitudes of the caregivers of dementia patients on the topic of the quality of care is the ABC Model of Attitudes. According to the model, attitudes have three components: affect, behavioral intentions and cognition (Ostrom, 1969).

Figure 15: ABC Model of Attitudes (Ostrom, 1969).



The three components are found to correspond. The component of cognition is responsible for the individual's beliefs, opinions and memories. The component of affect presents the emotions and feelings on the topic that the individual develops towards a certain topic, and the component of behavioral intentions presents the tendency to behave in a certain way toward the subject of the attitude. It is expected that the individual's attitudes will significantly influence his behavior (Ostrom, 1969). However, in reality, as research studies show, the relationship that exists between attitudes and behavior is weaker than anticipated. In human society, attitudes are perceived as stable over time and thus they are differentiated from temporary emotions. They are general and address many situations and/or people. In addition, attitudes express the positive or negative attitude towards the subject for whom there are attitudes. In addition, attitudes can be of differing intensity, and therefore their importance in the individual's life changes according to their centrality in his life. The importance of attitudes in the individual's life is decisive: they help in adjusting to a changing environment and responding to different events. The existence of attitudes not only helps the individual make decisions on different topics but also contributes to the preservation of the self-image. The model's ability to explain the individual's decisions and behaviors based on attitudes enables the explanation of health behaviors and different decisions in this arena of social life. For instance, the donation of blood is a behavior related to the individual's positive attitudes towards the topic, which are based on the belief that giving blood is a positive act (Farley & Stasson, 2003).

According to Van Ryn et al. (2011), the ABC Model of Attitudes can contribute to the understanding of behavior and the making of clinical decisions among caregivers, even when the behavior and/or decision-making occurs unconsciously. Historically, caregivers from all the medical professions have a high personal commitment to fairness, unconditional justice, integrity and preservation of the equality of patients in receiving medical care. Equality and respect in care for all, regardless of differences of race, sex, blood and sexual preferences are the main values in the community of caregivers around the world. However, there is a growing number of instances in medical care that are perceived as discrimination by caregivers, based on patients' affiliations with various social groups. In addition, research studies indicate that when a caregiver and patient belong to different social groups or to a different social economic status, the frequency of racist or discriminatory events in the communication between them increases. For instance, a white physician who holds negative attitudes towards the dark-skinned population will tend to make different clinical decisions for a white patient and for a dark-skinned patient, even when this is the same diagnosis. It is necessary to continue to study the contribution of the Attitudes Model in the understanding of the attitudes of different healthcare workers (Van Ryn, et al., 2011).

5.2.3. The Influence of the Attitudes of Formal Caregivers on the Quality of the Care of the Elderly with Dementia through a Combination of Two Models: ABC Model and the Model of Karasek:

For the finding of an explanation for the quality of the care that the elderly who have dementia receive, through the attitudes of the caregiving staff, a model was created based on the combination of two models: the ABC model and the model of Karasek. To the best of my knowledge, this is the first work that attempts to use a combination of the two models among caregivers of the elderly who have dementia.

The attitudes of caregivers regarding patients and their care considerably influence the process of recovery and the nature of the care that the patients and their families receive. Even if we were to imagine for a moment a reality in which there are institutions with an abundance of resources, without optimal treatment by caregivers the existence of care is impossible. According to Asamani et al. (2017), negative attitudes towards patients among nurses lead to deficient care outcomes. In their opinion, a situation in which caregivers humiliate their clients because of certain medical situations is not common but does exist, especially when talking about governmental institutions for the care of chronic patients. To avoid a situation in which patients feel humiliated and disrespected by caregivers, they will avoid receiving medical care in the designated institutions and thus will turn to herbalists or religious clerics who promise healing. It is not at all surprising that the patients will turn to the services of unconventional medicine. Many patients report that in their appeal to practitioners of unconventional medicine, they are accorded a respectful attitude, personal contact, empathy and dedication for a lengthy period that are not seen in institutions of conventional medicine. According to Asamani et al. (2017), the public at large does not have arguments about the skill and quality of professional care of caregivers; rather there is a lack of an emotional approach to the care, a lack of empathy, humiliation and disrespectful communication on the part of the caregivers - this is the main factor contributing to the avoidance of medical care among patients. In other words, the negative attitudes, some of which are enrooted in society, of nurses towards certain patients harm the central professional values of caregivers and cause them to provide care in a nonprofessional manner (Asamani, et al., 2017). Conversely, caregivers who adopt positive attitudes towards patients and their care take social responsibility for the prevention of stigmatization. It should be noted that the improvement of attitudes is essential for the providing of equal and just care to all patients regardless of the nature of the illness. Furthermore, the change required is not only necessary but also possible (Srinivas, et al., 2018).

Attitudes of caregivers toward the elderly with dementia and their care are influenced by three components: **a**ffective components, **b**ehavioral components, and **c**ognitive components. The three components influence one another and together create the caregivers' attitudes. That is, the variety of emotions, beliefs and behavioral intentions toward certain patients creates the caregivers' attitudes and comprises their personalities. Attitudes help in seeing situations in a certain way and behaving according to the view they established. Even when caregivers provide care to their patients, they rely on the same attitudes that accompany them in all areas of life (Asamani, et al., 2017).

A – Affective component. These are the emotions that the caregiver feels towards elderly dementia patients and/or the care of dementia patients. In other words, do the elderly awaken the caregiver's positive emotions? Does the care of the elderly with dementia lead them to happiness and enjoyment and is it performed out of good will or do caregivers feel that they provide care out of lack of choice or out of disgust towards the issue?

B – Behavioral component. These are actions or behavior intentions that the caregiver adopts based on emotions that he feels towards the elderly with dementia and their care. In other words, the caregiver who declares that he does not want to work with the elderly sees this as something superfluous, has negative emotions towards the elderly, and therefore actively avoids interactions with these patients.

C – Cognitive component. This includes the knowledge, beliefs and thoughts of the caregivers towards the elderly in general and towards dementia patients in particular. According to Asamani et al. (2017), the cognitive component is influenced by the individual's cultural patterns. For example, one of the common cultural values in Western society is "real men don't cry". Thus, the nurses' attitudes towards the patient who cries will be negative, and so too the nurses' behavior towards the patient (Asamani, et al., 2017).

The behavioral component of the caregiver towards the elderly person is influenced by emotions and the cognitive component. To the same extent, the knowledge and beliefs influence the emotions that the caregiver brings with him to the caregiving interaction with the elderly person. Thus, when the caregivers' knowledge and thoughts about the elderly are positive then they will feel enjoyment from the work and will want to provide a good level of care to the elderly. When emotions and thoughts towards the elderly are negative, the caregiver will refrain from the care of this group of patients. The attitudes of caregivers towards the care of patients with dementia will be negative. For example, Asamani et al. (2017) maintain that nurses in modern Western society compose their attitudes according to the financial value that characterizes contemporary society. Thus, nurses no longer work for love, giving or freedom; they work in return for payment. Hence, a society in which money buys good medical services cultivates caregivers who treat their work solely as a source of livelihood. Therefore, clients (patients) who can pay for the service will awaken in the caregiver positive attitudes towards them and their care. In contrast, when groups of patients do not compensate caregivers and the system itself does not, caregivers will develop negative attitudes towards the patient (Asamani, et al., 2017; Srinivas, et al., 2018).

It is possible and even necessary to improve attitudes among caregivers. It is possible to do this by inculcating knowledge and increasing exposure to patients. Thus, the promotion of positive attitudes not only improves the quality of medical care but also brings about a change in stereotypes in society regarding patients with certain illnesses, such as infectious diseases. In addition, it is necessary to remember that caregivers' true attitudes are commensurate with their cultural perceptions, and therefore the promotion of positive attitudes among caregivers begins with the change of the cultural perception in society (Srinivas, et al., 2018).

When negative attitudes are created towards the care of dementia patients, they will contribute to job demands that the caregiver must fulfill, such as, for example, working in shifts, considerable responsibility, lack of hope in the care, long hours, emotional load, physical load and so on. According to Jalilian et al. (2019), these causes, and many others, lead to the creation of tiredness from which nurses suffer in their work. Moreover, nurses do not receive enough time between one shift and the next and during the shift to recover and "recharge their batteries" for their work (Jalilian, et al., 2019). It is important to note that coping with stress, a feeling of burnout, a sense of mental well-being, or frustration is directly related to the caregiver's personality (Ruokangas, et al., 2020). Thus, the choice of caregiver suitable to the role according to the requirements may strengthen the mental well-being of both the caregiver and the patient (Bury, et al., 2019). Even when the level of burnout is similar, younger nurses as opposed to older ones will tend to leave the workplace. In other words, the positive meaning that nurses above the age of forty attribute to their work helps them deal effectively with the requirements of the caregiver's role and compensates them. However, nurses' departure from the workplace is not the most severe outcome for the organization. Researchers from Holland direct attention to nurses' departure from the profession and define it as a most severe outcome with destructive implications in the dimension of public health and the health system, especially in the modern era that is characterized by a severe lack of caregivers, the aging of the population, and the steadily increasing use of medical services in modern Western society as a whole (Van der Heijden, et al., 2019).

The situation is similar in Israel. According to the findings of research carried out in Israel, it is possible to see that although the population in Israel has increased by 65%, the health system has only added about 21% more beds. In other words, a lack of nurses in the health system constitutes one of the significant challenges in the health system. The situation is even more difficult when the percentages of caregivers who engage in providing medical and health services among the population of the elderly in Israel are mapped. Without a doubt, the discovery of innovative medical technologies has enabled the treatment of many medical situations that in the past could not be treated. Modern medical services given to the population in Israel extend the lives of the elderly and the chronically ill. In addition, the use of these technologies in public medicine has meaningfully changed the nurse's role in comparison to the role in the past. Most of the technological innovations not only have not reduced the nurses' workload but have also created additional demands in their role (Nirel, et al., 2015).

The role requirements are not the only burden placed on the caregiver's shoulders. Personal chronic illness, personal loss, multiplicity of professional tasks beyond the fulfillment of the caregiver's role – all these factors and many others contribute to the general demands from the caregiver. The lack of a sense of control, the feeling of lack of choice, and powerlessness regarding work hours, the amount of load, and the responsibility beyond logical proportionality cause nurses' chronic illnesses, such as muscle and bone pain (Freiman, et al., 2016). Researchers from Poland who examined the role requirements of the caregiver among nurses maintained that nurses are exposed to patients in severe situations of illness and to challenging families for a longer period than other caregivers. Thus, the requirements of the role among nurses are more numerous and more complicated, and along with personal chronic illness, they not only harm the satisfaction of nurses but also endanger the quality of care they provide (Kowalczuk, et al., 2015).

Some researchers maintain that the reference to caregivers as one group is incorrect. The group of caregivers is diverse, and therefore different caregivers are far from similar. Thus, their psychological and physical needs will be completely different from one another. However, research carried out among occupational therapists found that load, chronic tensions and the lack of time that accompanies the work increase the role demands and cause burnout and the desire to leave. In addition, the rise in the time of exposure to the patient population contributes to an increase in the tension from the work and causes harm to the caregiver’s health. This issue is especially prominent among nurses, whose exposure to patients in difficult situations is greater than in other groups of caregivers (Ruokangas, et al., 2020).

Furthermore, in research studies, it is prominent that feelings of load and frustration, lack of control, and especially low satisfaction characterize the caregivers who work with the elderly and with the elderly who have dementia (Ruokangas, et al., 2020). The findings of a research study performed in Holland emphasize the difference between different sectors among caregivers. In their opinion, the work of the nurse includes dealing with death and severe illnesses that pose a great psychological and physical challenge. This type of activity, which entails difficult conditions, creates a burden and tension, which create the unique role demands in the nurses’ work (Nirel, et al., 2015). In addition, Asamani et al. (2017) support these findings. In their opinion, a salary that is low relative to the difficulty of their work causes the nurses to work for a number of employers at the same time to earn more. The issue not only adds to the tension and load in the nurses' work but also causes negative attitudes towards the profession as a whole (Asamani, et al., 2017). A research study carried out in Poland among organ donor coordinators presented similar findings. As the exposure to difficult medical cases and death is greater, the harm to the coordinators' mental well-being is greater. It is important to note that in contrast to the nurses, the role of the organ donor coordinators is characterized by professional isolation and lack of social support from peers throughout the carrying out of the role. Consequently, the meantime for the filling of the role of organ donor coordinator is relatively low, compared to other types of caregivers (Bury, et al., 2019).

Thus, personal demands strengthen the negative influence of job demands and together intensify the negative outcomes that are divided into two dimensions: organizational and personal (Karasek, 1979). On the organizational level, the negative outcomes are the caregiver's departure, unplanned absences, harm to the atmosphere among the staff, increase in the rate of violence towards colleagues and patients, medical mistakes and human errors, decline in taking responsibility, decrease in motivation, low productivity (Bakker, et al., 2000; Jalilian, et al., 2019; Kowalczuk, et al., 2019). Researchers from Greece present similar results in their research. In their opinion, the worker's well-being and the safety of the care in the organization are two sides of the same coin. A caregiver with a low feeling of well-being is an indication of a lack of safety in medical care. Thus, the great risk to the quality of the care is the caregivers themselves (Panagopoulou, et al., 2015). Furthermore, according to Jalilian et al. (2019), a nurse who is found under tension, under a great workload, necessarily will suffer from chronic exhaustion. Work from tiredness increases the risk of human errors during care (Jalilian, et al., 2019). In addition, the rate of error in providing care increases as the nurses' level of tiredness increases. Errors in providing medicinal care and other errors entail high costs to the system (Cheng, et al., 2020). The many negative outcomes intensify the level of harm, both organizational and personal. Great tension and tiredness, multiplicity of tasks, some of which are carried out by nurses although they are not a part of their professional duties – all these and other causes create an atmosphere of tension over lack of time, nervousness, fear and anxiety and mistakes in giving medication or causing harm (Kowalczuk, et al., 2019). In addition, as a caregiving sector more exposed to patients and their family members, nurses much more than other caregivers are influenced by the nature of the atmosphere in the organization and by the staff of nurses in the ward. Researchers from Poland hold that the lack of a suitable and respectful atmosphere in the organization and the staff of nurses harms the nurses’ satisfaction and imposes a high personal and organizational price. Thus, nurses with chronic illness with low mental and physical well-being not only will be characterized by a high rate of absenteeism and low satisfaction with their workplace but also will endanger the patient’s health or life (Kowalczuk & Krajewska-Kulak, 2015).

When positive attitudes are created in the caregiver, they will contribute a source of energy that the role grants to those who fill it. In other words, positive attitudes created among patients contribute to the resources that the workplace gives, or job resources, such as occupational-financial security, empowerment, peer support, respectful attitudes from superiors, and so on. As the role demands, the caregiver’s resources draw their power from the caregiver’s dimension, or personal resources, which are the resources every caregiver possesses. For example, individual abilities, mental resilience, a social support system outside of work, and additional resources are defined by the caregiver himself as contributing to positive energies, causing good feelings, and strengthening the caregiver in everyday life (Jalilian, et al, 2019). Bury et al. (2019) emphasize the importance of cultural components in society in the mapping of the resources for coping with the demands of the caregiver’s job. In their opinion, the high social value attributed in Poland to families increases the emotional meaning of the support given by family members and spouse. The informal social network of caregivers constitutes a most meaningful source of mental wellbeing for the caregiver (Bury, et al., 2019). In addition, the caregiver’s involvement in making organizational decisions, a true interest in organizational activity, gives the caregiver not only a feeling of satisfaction and security but also a feeling of control and increases the feeling of mental well-being (Ruokangas, et al, 2020).

The combination of personal resources and job resources increases positive outcomes (Karasek, 1979), for example, better caregiver health, reduction of unplanned absences, willingness to help, initiative that leads to benefit for the organization, contribution of the caregiver to the improvement of organizational processes, mental wellbeing, personal happiness, and a good organizational atmosphere. Thus, the positive outcomes, like the negative ones, are divided into two levels: organizational and personal. Here, too, these two levels influence one another and are found in relations of reciprocal dependence. Hence, for example, the findings from research carried out in Estonia among nurses emphasize that nurses who feel respectful attitudes and appreciation in their workplace are healthier than nurses who define their environment as disrespectful and thus they do not take planned absences from their work (Freiman, et al., 2016).

Other research studies also found that caregivers who excel in their work contribute to a higher quality of care. Today, in the modern era, the quality and safety of care on a high level has become a natural product required by society from the health system (Cheng, et al., 2020; Panagopoulou, et al., 2015).

The demands of a person who is found in a terminal medical situation will always be at a high level. Therefore, it is not possible to expect mutual reciprocal relationships between the caregiver and patient. The achievement of balance between the role demands and the worker's resources is a constant aspiration on the part of caregivers with the constant search for sources that contribute to their mental and physical well-being (Bakker, et al., 2000; Demerouti, et al., 2001).

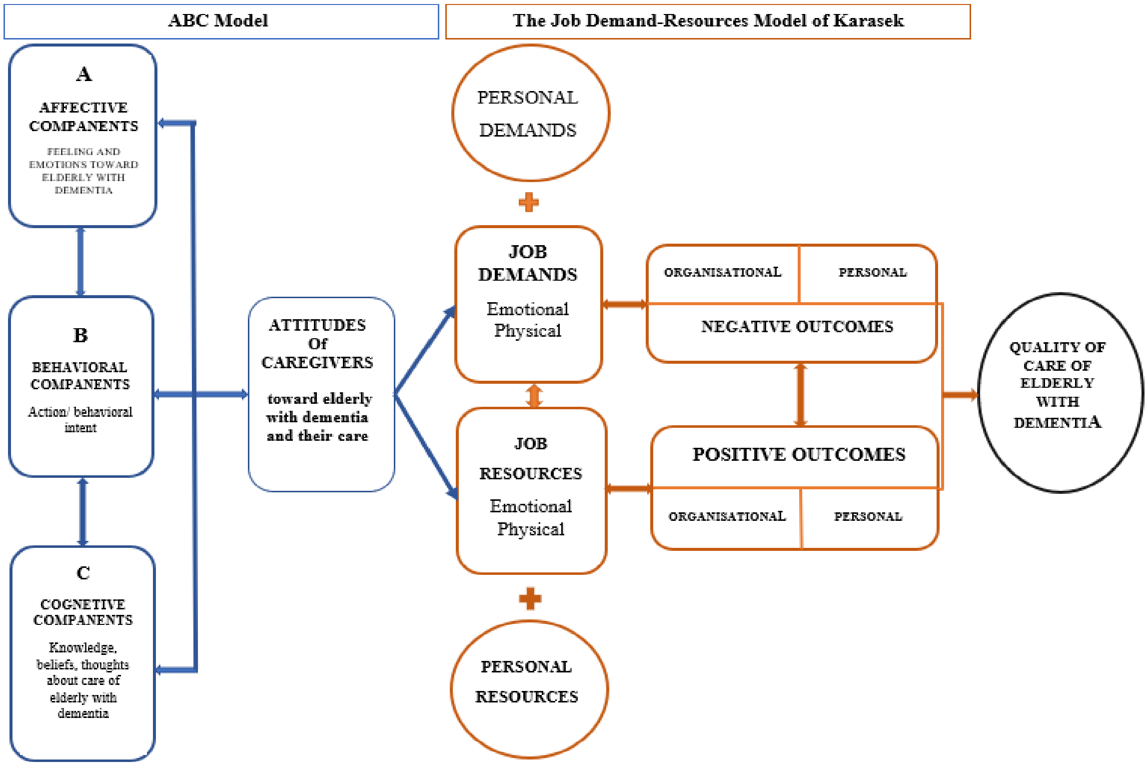
When the balance between the caregiver's demands and the available resources is disrupted in the direction of the demands, the level of stress increases. It is possible that as the balance is disturbed, irreversible damage can be created on both a personal and an organizational level. The implications in this case are destructive. A caregiver who feels burned out and repressed does not provide quality care (Panagopoulou, et al., 2015). This finding is not at all surprising. Every person whose role is to provide service to an audience, in other words, a person who works with other people, tends to have a greater propensity to professional burnout. The mutual relationships in society rely on the demands to obtain services on the one hand and on tension related to the finding of creative ways to fill the demands on the other hand. The factor that is supposed to provide the required services and invests in this more than they can reaches a situation of exhaustion (Bury, et al., 2019; Demerouti, et al., 2001).

It is necessary to preserve the balance between the caregiver's demands and the resources necessary to ensure the quality of care for patients who have dementia. Thus, when the balance is disrupted in the direction of the demands, there is an increase in the level of stress under which the caregiver lives and works. In addition, negative outcomes will increase, and the level of quality of care for dementia patients that the caregiver can provide decreases. Conversely, when the balance is disrupted in the direction of the resources, the quality of the care of dementia patients rises.

The model is dynamic and responds to the changes in it. Caregivers may provide care of another quality when they feel personal loss or another personal crisis.

The quality of care for dementia patients is first and foremost a result of the caregiver's beliefs, knowledge, thoughts and behavioral intentions. The attitudes created following the three components (affective, behavioral, cognitive) contribute to the resources or requirements and consequently create a more negative or more positive organizational and personal reality, according to the created results. In addition, created negative attitudes can be changed by direct influence on their cognitive component. In other words, providing relevant knowledge and current information may change the caregivers' negative attitudes to more positive ones (Asamani, et al., 2017). The improvement of the attitudes of caregivers of the elderly with dementia is necessary for the improvement of the quality of care for elderly dementia patients. This can be done in a variety of ways.

Figure 16: A Combination of Two Models: ABC Model and the Model of Karasek.



5.3. Research method:

For the performance of the present research study, use was made of the qualitative research method. The research instrument is a focus group.

The choice of qualitative research was made to achieve a deeper understanding of human behavior, and the quality of treatment for the difficulties of dementia patients. The subjects of the research were formal caregivers, such as nurses and doctors, as well as auxiliary staff - the main actors in the issues discussed in this work. The recruitment to the focus group in this research is essential, since the interpersonal interaction that is expected to develop among the participants may bring up thoughts, emotions and opinions on the research topic. In addition, this method of research enabled us to go in depth into the details of the topic and this helped us discover multiple diverse facets of the researched issue.

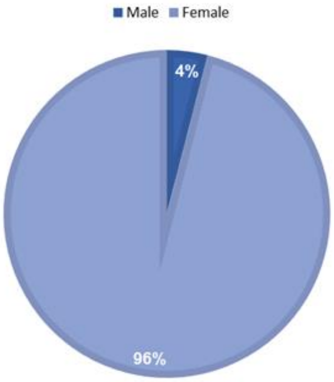
The discussions in the groups were performed with the support of an instructor and were structured. The topics that were discussed in the focus groups were the quality of life and quality of care of the elderly in general and dementia patients at the end of their lives in particular, the right to dignity and choice at the end of the life, and the right to die with dignity. The method of the focus group, which was chosen for the performance of the research, not only helped identify the participants' attitudes and perceptions but also created a convenient platform for the raising of emotional content, for example, deliberations and frustrations, regarding the research topic.

5.4. Description of the recruitment process and research group:

To conduct the study, a notification was shared in a public WhatsApp group for nurses to recruit participants. This notice outlined the study's topic and methodology. In the next phase, the research supervisor organized a meeting schedule and formed discussion groups. Notably, due to a strong interest among the nurses and their eagerness to participate, more participants were recruited than initially anticipated. Following different constraints stemming from the pandemic, the research population was limited to only nurses and nursing assistants.

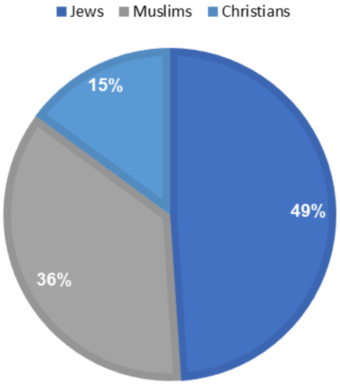
For the research, a cohort of 47 participants comprising both nurses and nursing assistants was enlisted. Predominantly, the participants were female, accounting for 96% of the group (45 individuals), a trend unsurprising given the historical association of nursing with femininity.

Figure 17: Gender of participants.



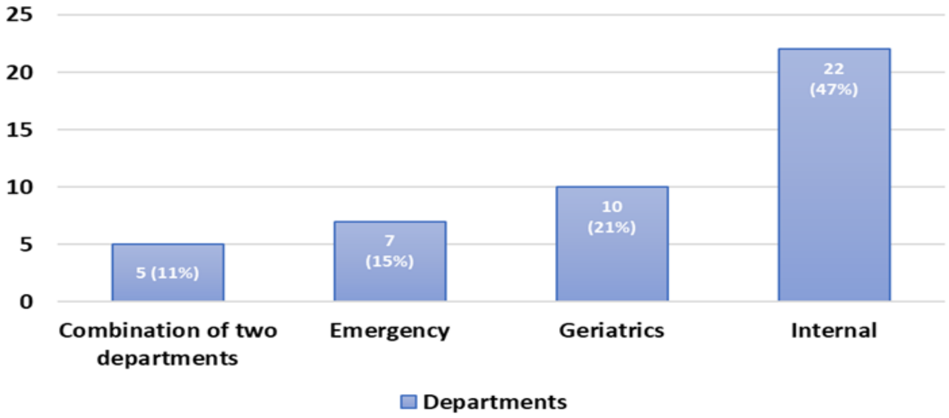
Among the nurses surveyed, approximately 49% (23 individuals) identified as Jews, while around 51% were Arabs. Within this group, 15% (7 individuals) identified as Christians, and 36% (17 individuals) identified as Muslims.

Figure 18: Religion of participants.



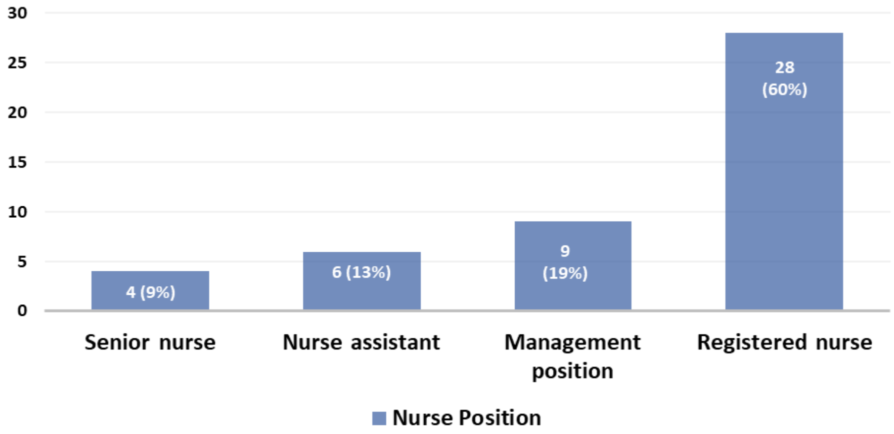
In terms of specialization, the majority of nurses, approximately 47% (22 individuals), were employed in internal medicine departments. About 21% (10 individuals) were assigned to departments specializing in geriatric care, with 15% (7 individuals) working in trauma and emergency units. Additionally, 11% (5 individuals) juggled roles across two different departments, while 6% (3 individuals) were involved in oncology and community care.

Figure 19: Division of nurses by departments.



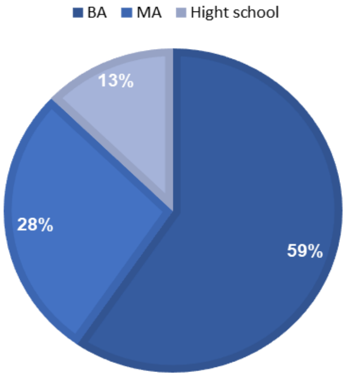
Among the participants, 60% (28 individuals) were registered nurses, while 9% (4 individuals) held senior positions on the clinical scale. Approximately 19% (9 individuals) assumed managerial roles such as head nurses, deputies or clinical coordinators. Furthermore, 13% (6 individuals) of the research cohort consisted of nurse assistants.

Figure 20: Nurse position.



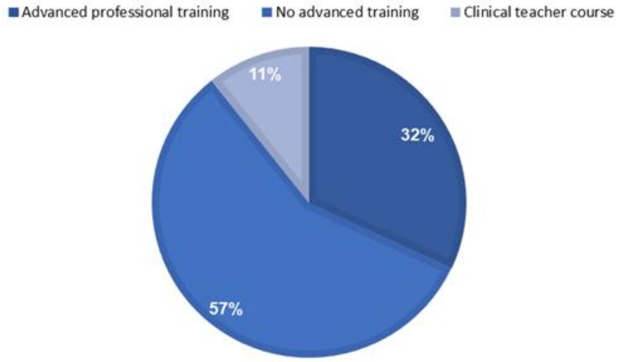
Educationally, a significant portion of the participants held a bachelor's degree (59%, 28 nurses), followed by those with a master's degree (28%, 13 nurses), and a minority with a high school diploma (13%, 6 assistant nurses).

Figure 21: Academic education.



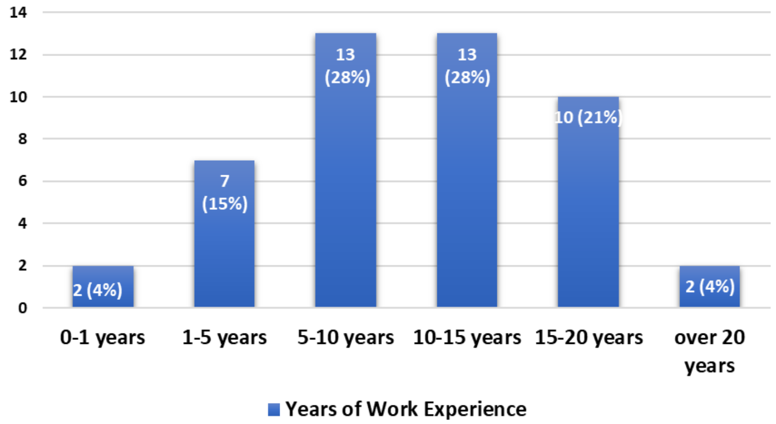
Regarding additional professional training, the majority (57%, 27 nurses) had not undergone further specialization beyond their initial education. However, 32% (15 nurses) had completed professional courses, and 11% (5 nurses) had not only completed such courses but also served as clinical instructors in nursing.

Figure 22: Professional courses.



In terms of tenure, the largest segment of nurses had between 5 and 15 years of experience. Notably, around 28% (13 nurses) had 5 to 10 years of experience, and a similar percentage had 10 to 15 years. Approximately 21% (10 nurses) had between 15 and 20 years of experience, with 4% (2 nurses) having less than a year and another 4% (2 nurses) having over 20 years of professional experience.

Figure 23: Years of nurses' work experience.



It's worth noting that the initial plan for the research study aimed to recruit approximately twenty participants. However, the study ended up attracting 47 participants, divided into seven groups, each consisting of six to eight individuals. Six of these groups comprised nurses of both genders, while one group was composed of auxiliary staff and caregivers.

The unexpectedly high response rate to the research can be attributed to the growing public interest in the topic of dementia care for the elderly, along with the escalating challenges faced by caregivers in this domain.

Due to the COVID-19 pandemic and associated restrictions on social gatherings, the focus groups were conducted virtually using the Microsoft Teams platform and recorded using Apowersoft Screen Recorder software. To facilitate data analysis, the discussions were conducted in Hebrew, transcribed, and subsequently translated into English.

Every participant was informed about the carrying out of recordings during the meetings. In addition, the recordings were performed and saved on a personal computer accessible only by the researcher.

In light of the considerable emotional involvement in the topic of the research, a formed opinion on the topic, and considerable professional experience in the care of the elderly, so as not to influence the expression of opinion of other participants, it was decided that the researcher would be present as an observer in the focus groups. To neutralize the influence of the researcher's opinion and avoid bias towards the researcher among the research participants, the services of a moderator, with knowledge and experience in guiding focus groups, were retained. To aid in the performance of the research study, a meeting was held between the moderator and the researcher, in which the expectations, work rules, time framework and so on were determined. The moderator received a sheet of guidelines for the moderation of the groups (Appendix Number 1). The moderator published a message in WhatsApp groups for health workers who work in hospitals in the north of the State of Israel. In this message, they were invited to participate in a research study of health workers with experience in the care of the elderly with dementia. The participants' age, gender and position in the health system did not constitute criteria for non-inclusion in the research study. In other words, every person who responded to the message and found one of the dates set for the focus group to be suitable and consented orally to participate was included. In addition, the necessary condition for inclusion in the research study was mastery of comprehension and speech in the Hebrew language, in order to allow a discussion based on equal communication among those recruited to the focus groups. The participants did not all know one another before the meeting. The participants did not know ahead of time who was participating in the group, and they could not join based on any interest aside from the desire to participate in a research study whose topic was known at the time of the publication of the recruitment message.

The meetings were limited ahead of time to an hour and a half. When eight participants were recruited, the group was closed for the recruitment of additional participants. The limitation of the number of participants to eight was undertaken to enable the participants to express themselves comprehensively while maintaining the time frame set for the existence of a focus group.

Every focus group was opened with the statement of rules for the holding of the group and binding guidelines, and then there was an activity among the participants to get to know one another. The participants were informed that there are no right or wrong answers and that every opinion has meaning and value. In addition, it was emphasized that there is no need for the participants to agree on the topics in the discussion. However, the participants were obligated to maintain confidentiality outside of the group and to exhibit respect in relationships during the discussion. Furthermore, in the framework of the guidelines, the participants were informed that they could freely leave the group at any time. In addition, the participants were informed about the role of the moderator and the observer (the researcher).

Immediately after the explanation of important emphases and behavior rules of the meeting, the participants were informed about the topic of the work. Then the open-ended questions were presented and a discussion began on the topic. The discussion in the group was held in the Hebrew language.

All the groups excelled in productive discussion, and there was full cooperation between the participants and the mediator. All the participants upheld the rules of behavior and addressed one another with respect, even when opinions were contradictory. In all the groups held in the framework of the research study, there was a pleasant atmosphere that enabled the expression of opinions regarding the questions presented for discussion. The time set for the discussion ahead of time was an hour and a half to two hours. All seven of the groups stuck to the time frame, with each participant having about five to ten minutes every round. The time was influenced by the number of participants in every group.

The main question from which the discussion in every group began was as follows. “What is your position regarding the quality of care provided to the elderly in general and the elderly with dementia in particular in medical institutions in Israel? What do you think? How does this make you feel?” The second question asked in the discussion, which is a result of the first question, was as follows. “What is your position regarding the performance of invasive medical actions (such as gastrostomy, intubation, etc.) that extend life without improving the quality of life of elderly dementia patients? What are the factors in your opinion that influence the carrying out of invasive actions in old age? What are the factors that should be taken into consideration before carrying out an invasive action?” Another question that for the most part summarized the discussions in the group and arose from the discussion was: “What is the meaning that you attribute to the concept of “dying with dignity” regarding the elderly in general and the elderly patients with dementia?

The discussion revolved around concepts such as “quality of life” among the elderly with dementia, “end-of-life plans”, and “the elderly person’s desire”. The conversation in every group was concluded with the question. “What needs to be done to provide high-quality care for the elderly and the elderly with dementia?”

Every meeting was summarized by the moderator, and the participants were given the possibility to focus, express and add to what was said in the meeting.

It is important to note that the participants did not receive any recompense, gift or benefit for their participation in the focus group. Their participation in the research study was completely voluntary.

At the end of every focus group, the moderator and researcher held a summary meeting, to conclude a variety of dimensions for the coming meetings.

In the first group, there were eight participants, six female nurses and two male nurses. Their clinical experience ranged from three to twenty years and included internal medicine wards in hospitals, community health–health maintenance organizations, hemato-oncology, imaging and emergency room.

For the second group, six participants were recruited, all female nurses, with experience ranging from eight to fifteen years, focusing on gastro institutes, palliative coordination, and internal medicine.

During the recruitment of the participants for the research study, the need to provide a platform for younger nurses was prominent. Thus, a third group was created, in which there were six participants, five female nurses and one male nurse. Their experience in the relevant field ranged from two months to five years and focused on internal medicine wards, neurology and institutions for the elderly.

For the fourth focus group, six female nurses were recruited, with experience of eight to fifteen years. They were senior nurses in different fields, and their experience included internal medicine wards and institutions for the elderly.

The fifth focus group includes six female nurses and a male nurse, with experience of seven to fifteen years in cardiology and internal medicine.

For the sixth group, eight participants were recruited, two male nurses and six female nurses, senior staff (management) with experience of five to ten years in hemato-oncology, internal medicine wards, surgery, heart failure clinics, and respiratory intensive care.

The last group, the seventh group, represents assistive personnel and caregivers, with experience ranging from two to six years in internal medicine wards, institutions for the elderly, and a dialysis institute.

5.5. Presentation of research results:

As a basis for discussion of the focus groups in the present work, topics were discussed, such as the quality of care, death with dignity, and difficulties entailed by caregivers' everyday work with the elderly in general and with dementia patients in particular. Caregivers from the seven groups expressed their opinions on the topic of invasive procedures, the interaction of caregiving staff with family members of dementia patients, and suggestions to improve the situation.

The general attitude of caregivers regarding the quality of the medical care provided in Israel is positive. Nurses believe in the medical ability in public hospitals. They believe that medicine and nursing care enable them to give their patients a high level of care. One of the nurses expresses this as follows: "I think that the care in Israel is among the highest quality that the general public receives in comparison to the care provided around the world. Everyone receives food, medicines and clean linens. Today in Israel medical care in public hospitals is given according to the high standards determined by JCI… I think that in many other places in the world, this is not like this at all." (P.10)

Other nurses with experience in the profession of 5-10 years think similarly and express this as follows. "… the medical ability in the State of Israel is among the highest in the world with uncompromising professional nursing care. And… with the peak of the ability and multiplicity of resources (not a limitless abundance!!!). Access to these resources is highest for a broad public… in other words, there is access for all. Everyone can receive excellent medical service. Without any difference. This is accessible for all." (P.14) "The medical care is excellent! Among the highest in the world… and all this is almost free in terms of personal costs." (P.29)

In contrast to the positive attitudes towards the general medical care provided in the health system in Israel, most of the participants in the research study express negative attitudes towards the medical and nursing care of the elderly in general and dementia patients in particular. The caregivers in the present research study maintain that the care of the elderly not only is suboptimal and unsuitable for the elderly but also may harm them. "One care for all. Public medicine is one for all. What there is. This is something mediocre. And therefore, it does not suit anybody, but it largely meets major needs. For example, emergency… one of the best in the world… does all that we know how to do need to be done to the elderly? A big question… their ability to survive this treatment… must also be taken into consideration. The care is excellent in terms of the medical ability… less suited to the elderly… I think…" (P.12)

The rest of the participants in the research study expressed similar opinions regarding the quality of care among the elderly. "There is no ideal care. There is no optimal care for the elderly as well. The care ranges from good for the elderly to bad for the elderly. The care is mediocre or even in the direction of bad for the patient." (P.5) In other opinions, "Optimal or ideal care – they confused it with maximal care. In my opinion, maximal care is equivalent to 'bad', and is equivalent to 'many unnecessary invasive procedures that do not bring benefit to the elderly person'. We will do all that we know how to do… from a technical perspective, truly we have invested in the elderly. Applause for the most advanced medicine in the world... Is it good for the elderly? No!" (P.7)

The rest of the respondents expressed similar negative attitudes towards the quality of the care of the elderly and dementia patients. For example, "The care – mediocre…

poor…" (P.15) In addition, another emphasizes that "the medical care in Israel is on a high level, but towards these patients (the elderly and dementia patients) not really… there is nothing to be proud of, unfortunately… (P.17)

Additional focus groups present negative attitudes regarding the care of the elderly. Nurses with experience of many years in the care of dementia patients express that, "I am not afraid to say that the care is poor… care that everyone is ashamed of. And me too…" (P.20) Other caregivers not only express their position regarding the quality of the care of the elderly but also describe the reality in the field with which they cope every day in their work. According to other nurses, "Mediocre care. Perhaps in medical terms high… but not tailored to the elderly person, and his fragile body in particular. Come and see… he is lying down, alone and pitiful, hours upon hours… does not see anything aside from the wall of the hospital facing his bed. Once a shift, maximum twice, they come to turn him over … at best, to have a change of position." (P.21) "Acute hospitalization provides the elderly with care of a low quality. When a patient cannot express himself and cannot communicate… he will be the last to receive his food. Add to this the inability to eat… in short, the care is awful." (P.24) Another nurse (P.25) also describes a similar reality in her work. "The care is tying– before everything. So, I do not define this as appropriate care. On the other hand, there is nothing to offer… to provide antibiotic treatment in the vein, the patient needs to be tied since otherwise he takes everything apart and with this restlessness endangers himself and harms the care. This is a problem that does not have a solution in the health system of today." Furthermore, "the care is brutality towards the elderly. Describe to yourself that children are cared for this way… it is unthinkable! Right?… But the elderly are also helpless… completely alone in the hospitalization. They are ground up in the system and always lose." (P.31)

Many other respondents who participated in the present research study emphasize the gloomy picture regarding the care of the elderly. For example, "the care of people with dementia – is poor and is not even logical!" (P.32)

There is a witness of a similar reality in his place of work and maintains that the caregiver has the responsibility for the quality of the care of his patients. He expresses his opinion that "Unfortunately, rarely in acute hospitalization can it be said that an elderly person received holistic treatment, especially nursing, and dementia... something has happened to us (the nurses) .... there is no proper respect for the human body at all, and especially for the elderly person's body. It no longer touches me emotionally. Have we stopped feeling? I am afraid to answer this question for myself…" (P.34) Another participant also supports this feeling: "Care of the elderly… care in which the patient himself receives less attention than others. Less in terms of even the level of the food and drink … they receive less. They do not demand, do not ask, do not voice anything … they are more helpless than infants…" (P.37) "The care that does not respect the human desire. We (the caregivers) do not know what is preferable. Routine has killed consideration of the patient." (P.41)

In the opinion of the research participants, the quality of care begins from the physical conditions in which the caregiver-patient interaction occurs. During the discussions, different factors associated with the care environment were mapped. "First of all, it is necessary to create a good atmosphere… the hospital is a place of patients… for the patients and their benefit. I think that we have forgotten this since we are busy with everything and not with the elderly themselves." (P.9) "It is important to improve the physical conditions of those hospitalized. The elderly with dementia are hospitalized in the corridor. A paradox. The conditions are least suitable for them. And aside from this… we are also people. It is more pleasant to work in a quiet room, pleasant and lit… but in the dormitories… as dark as Egypt! Why do we not deserve to work in the conditions of the maternity ward?" (P.1)

In other groups as well, the importance of the physical conditions of the hospitalization is discussed. "Before everything, more appropriate physical conditions for care are required. In other words, more comfortable and nicer rooms. Fewer patients in every room. Also, relaxing background music… is nice. At least it will be clean and quiet. The minimum that does not exist in most public hospitals. Everything is old and falling apart. It looks bad." (P.32)

Despite the considerable emphasis given by the participants in the research on the physical conditions in the care, emphasis was placed in all the groups on the nature of human care, care from empathy, caring and compassion. "We must bring emotion and compassion to the care of the elderly and especially dementia patients. Good and cheerful care can be provided in a field of tents…” (P.3) Another participant maintains this: “… like in every contact with people, it is important to provide a more cheerful response, empathetic. It bothers me to insert a tube just because I do not have half an hour to feed the elderly and there is not enough help. What is better? To have pity and not insert a tube? Or to only see his clinical good and… it does not matter how this good is achieved???” (P.20) Another participant also recommends, “To see the elderly person at the center. To prevent further confusion through the creation of a quiet environment suited to the elderly person’s needs… think about teeth, glasses, and aids that maintain independence. If there aren’t enough caregivers, then recommend to the family another caregiver, private, at least to cover some of the hours. We in the hospital cannot provide an appropriate response for the elderly person…” (P.5) A further participant also expresses the same stance. “The creation of suitable service for the elderly person in hospitalization. At the moment, this does not exist in my opinion. Like there is pediatric medicine for children. Really on such a level. There is less investment in the elderly. Not only in resources… in general in the level of thinking… to think that the elderly are not important to our future, as a society… this is a mistake. But this is how it looks like.” (P.10)

In emotionally difficult work, it is easy for the caregivers to shift in the direction of task-oriented work, technical, devoid of feeling. However, biomechanical work without emotional investment and a human attitude does not lead to good outcomes in medical care, especially for patients with cognitive decline, such as dementia patients. Moreover, automatic work without emotional investment in activity harms the caregivers themselves in the long term (Nicolas, 2014).

The unfortunate situation described by the caregivers in the present work is not at all surprising. Olsen et al. (2015) hold that the elderly who are cared for in their home, an environment that provides them with privacy and quiet, have a better quality of life than the elderly who spend the rest of their lives in a medical institution that cannot provide comprehensive care.

Many caregivers raised in the discussion on the quality of care the need for relations of respect in the care, as an assurance of the quality of the medical and nursing care. In the opinion of many respondents, this component is lacking in the care of the elderly, especially when talking about dementia patients. Thus, “Care of the elderly… is not commensurate with the requirements. And sometimes it does not respect them. Nobody knows what to do with the elderly person… who most of the time is tossed into the hospital for the period of the holiday… and is forgotten, so as not to make ugly the picture of ideal happiness at home.” (P.6) “The care is without minimal respect that every human being deserves. If this is the excellent care that everybody talks about, then I prefer to die before the hospital gates.” (P.21) Other nurses also see the care of the elderly in a similar manner. In their words: “An elderly person receives less dignity in care” than other patients. “There is no respect in the care of the patients, not for the caregivers and not for the patients themselves”; “There is discrimination based on the background of age towards the dementia patients.” (P.4) Like the other caregivers, this participant says, “I do not believe in the ability of the system to give the person dignity… whether this is a patient or a nurse.” (P.21) Some caregivers see the responsibility for care devoid of the dignity of the elderly to be a social responsibility and see the root of the problem in the ignoring of social values according to which a society that respects old age acts. She says, “There are no values of respect for old age… the young generation no longer appreciates wisdom. There is Google! It is necessary to enroot the values of respect for the elderly person. There is a decline of these values in society…” (P.22)

The elimination of values that respect the elderly person’s status is a phenomenon that embraces every modern Western society. According to Bai Xue (2014), the status of the elderly in Western society today is negative. The different social stereotypes against the group of the elderly perpetuate the situation. In his opinion, the system of beliefs entrenched in society, according to which the elderly person in society is a burden, builds a system of negative stereotypes. Furthermore, the elderly themselves grow older with a feeling that a person who ages must yield his place to the younger people, who inevitably can contribute to human society more. In addition, Margaret Mead (1973) supported the feelings of modern caregivers. She asserted that the elderly are exposed to negative stereotypes about old age all their lives. Thus, it is hard to believe in their ability when they are old to change the thinking that is so entrenched in their minds.

Furthermore, some caregivers maintain that the care has stopped being a complete response to the patient's needs. The accepted care provided today for patients includes only their acute medical needs. Thus, as the rest of the caregivers involved in hospitalization said, the elderly and dementia patients do not receive holistic care but receive "care depending on their acute medical situation, without tailoring to age and sex. Only the situation of the acute sickness is seen, and not the patient as a whole" (P.4). The lack of an overall view of the elderly person's needs and consequently the lack of holistic care for the helpless patient, such as an elderly person who has dementia, have detrimental implications for both caregivers and patients in every stage of care. Thus, a nurse in the emergency room at a large medical center describes the reality. She says: "Caring for him (an elderly person with dementia) is sedating and tying him up, and then we start treating. We (the caregivers), no one knows what to do with them. You 'reset them' to take care of them, otherwise it interferes with work. Absurd... then move to a unit that specializes in working with the elderly. But this move... it's annoying. These patients are restless, they scream endlessly. Terrible stress for the staff and them." (P.2) The situation in other wards in a range of centers is similar. And the situation creates negative feelings in the caregiving staff. Thus, the internal nurse expresses, "… hospitalization in the corridor since there is no room, with light and noise that do not end even at night… this is ideal care? It is hard for me to call this humane care if I can expect such hospitalization – I would prefer to die a second beforehand." (P.1)

The care reality that is created disturbs many other caregivers. Thus, the nurses present this: "The care… this is in essence… 'to flip burgers' – to make changes in position - the protection of the nurse against emotional exhaustion. Simply not to connect. Dementia patients are the most hurt, from the beginning are more vulnerable than others." (P.5) "It is not heroic to care for the elderly person and certainly if he has dementia. This is not care to be proud of in the emergency room. An elderly person???? Don't be funny… this is not to save life. This is to be a victim since others fled from this care." (P.7)

Negative feelings of the caregivers that cause negative attitudes regarding the care of dementia patients cause them to wonder about the situation of these patients and to want to bring about a change in the reality of the care. Thus, for example, an internal nurse expresses this: “It is necessary to avoid getting close to the bed. A bed in the hospital is not supposed to be a living grave. It is necessary to take into account that this ‘quality’ is a subjective issue. And if we do not know what is quality in terms of the patient, then at least he will not suffer.” (P.32) Many nurses speak about the complexity of the care of an elderly person with dementia and emphasize the importance of the caregiver’s personal facet in the care: “The care is challenging and not only… care that will never give satisfaction to the caregivers. Since… the care is difficult and not rewarding in any way… is the care of quality? I do the maximum that I can in the given framework. Touching softly and slowly. Talk to them even when there is no answer. Caressing. What else is possible?” (P.9) Other participants see the considerable importance of the human component in the care of helpless patients. Most of them see caregivers as being responsible for the quality of the care, especially patients with dementia. In other words, “Care depends on the staff. To the extent that they are skilled and emotional. The time has come to understand that medicine for the elderly is a new type of medicine that we do not know.” (P.13) Another nurse expresses this similarly, “Personally I care for them like the other patients. But within the framework of the existing time and strength. I do what I can. I am not satisfied with the care, or the final product that comes out… but I do everything. This care causes burnout. You work hard and nothing comes out of it… but to care at half-strength? I would feel worse.” (P.15) Another nurse also sees her contribution to better care in her investment in the work. She asserts that the dedicated care she provides causes her to feel better in the care, although she does not interpret the care itself as appropriate. Thus, she expresses this in the group, “I feel bad about the profession during the care of the dementia patient. I would not forgive myself if I am not thorough in the care.” (P.20) Other participants share their negative feelings about the care. “I return home with feelings of guilt. The situation is not going to change, it will only get worse…” “The care of the elderly causes the nurses to develop anxiety.” (P.26)

Another nurse expresses the same feelings, “I will try to lend a hand to alleviate suffering through my emotional involvement. I will hold his hand. I will show a patient I care. That I do not act automatically. The care of dementia patients is exhausting, sad, predatory and destructive. That’s how I feel. I wish I could see that it helps them ... at least a little.” (P.30)

The feelings that arise in the discussions in the focus groups in the present research study are not surprising. Hazzan et al. (2016) called caregivers of dementia patients “hidden victims”. In their research, they maintain that there is significant harm to the caregiver’s quality of life. His feelings create anxieties and fears; in the end they cause the appearance of chronic mental illnesses. In addition, the care of the elderly, even when it is carried out at a high level, over time harms the caregivers’ mental well-being. Furthermore, caregivers who perform routine tasks throughout their activity over the years develop burnout, which causes them to want to leave the workplace or even the profession (Srivastava, et al., 2016).

Alongside the caregivers who see their personal involvement in the care and the ability to change things for the better, some attempt to avoid the care of elderly patients who have dementia. Another participant sees the situation like this: “I avoid caring for this type of patient. Deficient care… there is no respect from the management of the nursing care for the nurses. We are condescended to... What will the care of a nurse who is humiliated by the management look like? What can a nurse who is condescended to and not appreciated give in care? The attitude is as if we are slaves of the system... so is the care.” (P.22) The other participants express their frustration regarding the attitude of their superiors. “There are days that I hate my job… the one who manages me does not understand my true distress as a nurse. Nobody cares.” (P.23) “We give care according to the attitude we receive from our superiors… he who understands will understand.” (P.25)

Another response from a participant: “Care is technical, devoid of emotion. Not customized, and certainly not emotional… to provide emotional and quality care it is necessary to give me time to see the person in front of me … I do not have time… if I have more than 20 patients in the shift and with me a student who barely moves… some of the people will not eat… how will I live with this??? If I had the option of another job then I would not hesitate to leave… I have no choice. Like most of the aid staff… does somebody respect me? Does somebody see me as a person??? Then why demand of me to give of such level???? I come to work and try to get everything done… if I begin to put in emotion… I will die before pension.” (P.47)

According to the statements of many caregivers in the research, the attitude towards them on the part of society and their superiors is not at all surprising. The discussion in the focus groups indicates that the caregiver of the “rejected patient” becomes rejected by society and superiors. The caregivers who participated in the research maintained that the care they give to the elderly is also harmed. Thus, participants expressed this in the discussion: “The hospital cannot give excellent care to the elderly person with dementia, since it does not take his needs into account. In the hospital, there is care for the illness and not the elderly person. A person with dementia is a rejected patient, both a quiet one and a violent one. They are rejected by the staff and by other residents who do not want them near them.” (P.24)

Many other nurses in this study support the previous assertion and emphasize the negative attitude of the public toward hospitalized patients and their families. “… There is a very bad attitude towards these patients from the public… clear-headed people… I was in a situation where a clear-headed patient required care before an elderly person with dementia. I asked him to wait and he did not agree. He told me difficult things … ‘care for me and not his body’… and there are many like this… they are seen (the dementia patients) as human garbage, as chunks of meat… it is heartbreaking…” (P.42) Another nurse shares a similar story from her professional life, “… a problem is when clearheaded patients are mixed with those who are not clear-headed … I feel uncomfortable… some people think this is a waste of personnel and resources… and think that if I had not provided care now for the dementia patient, then I would be more available… there are many such patients and many families…” “There are many rejected patients… the elderly person with dementia is not the most desired patient... when the care is good, everything is good. This is a patient who is not given sweets… and is not grateful. But he also does not write complaints.” (P.46)

There are participants in the research study who see the “rejected patient” as one side of the coin where the other side is always the “caregiver of the rejected”. Another nurse emphasizes “Mediocre care. Poor. This is the normal care of the rejected patient… the care of Alzheimer’s makes me feel bad. This means that in advance I agree to mediocre and poor treatment, not considerate. I feel bad for succumbing to a system that does not know what to do with these elderly people. To be a part of the system that rejects ... me too as a nurse ... " "Who do we take care of? People or practice dolls???" (P.15) Another participant asks angrily. "Then… the care that we give is fundamentally lacking in humanity… the care is convenient for us, the caregivers. It is technical. It is devoid of feelings, and lack of caring. The attitude towards the outside… from each one… is similar. I am rejected, like my patients." "Nobody will tell you: 'Wow you saved the old person's life!'… this is a burden and not care. A person who wants to be a hero goes to care for others. Not for the elderly. A person who remains to care for them – becomes second class." (P.14) During the discussion of the focus groups and in light of the negative attitudes held by the caregivers who participated in the research, the respondents were asked what, in their opinion, good care of the elderly in general and elderly dementia patients in particular looks like among caregivers. The participants in the research study want to see the care of the elderly on a high professional medical level, with emotional involvement and respectful relationships. In the caregivers' opinion, elderly dementia patients especially need such care more than the rest of patients in hospitalization. Thus, for example, "Optimal care, which is good enough, this is the realization of the maximum of the resources existing for the patient's good. For the dementia patients – with the addition of compassion." Other participants also see the good care of the patient with dementia in a similar manner. For example, another nurse expresses this, "… emotional investment. To speak and to touch – this is more important than to hand out medications, especially when he (the dementia patient) does not want to take medications." (P.7) Another participant maintains that "The care of them must be sensitive and not technical." "The ideal care, or at least good, is palliative, gentle, and sensitive. Without unnecessary 'heroics'. Without unnecessary tests and invasive medicine instead of conversation, relationship, and touch." "The care needs to be full of compassion and multidisciplinary…" (P.17) "The best care is supposed to encompass the patient emotionally… especially when the patient is like a helpless child… like a dementia patient." (P.30) In addition, according to another participant, "The quality of life in care is important. But it is not the most important. The elderly people must have different care. Customized, sensitive, and more considerate. Cold and alienating care – not suitable!" (P.33) Participant number 34 supports these statements: "The elderly need different care. Caressing, gentle, but also professional. And there it is!" (P.34)

During the discussion regarding the quality of care of dementia patients, the topic of the carrying out of invasive medical procedures, such as the insertion of a breathing tube in cases of respiratory insufficiency, insertion of a feeding tube for mechanical feeding, insertion of a pacemaker, and so on, was discussed. Some of the invasive procedures, such as the insertion of a breathing tube or pacemaker, are lifesaving medical actions. But there are other invasive procedures, such as the preparation of the feeding tube and major infusions, which are known not to prolong life. Caregivers who supported the carrying out of invasive procedures maintained that every human life has supreme value, regardless of diagnosis and caregivers have a moral obligation to perform all necessary actions to save lives. Thus, "To do everything. This is exactly the difference between a humane society and another society. Whether there is one diagnosis or another… even in young people… so we will not do anything???? Who decides???? To do everything! This is humane!" (P.11)

Other participants also see decisive importance in the value of life as a supreme value in society. In their opinion, this is the most important value that guides caregivers in the care of dementia patients, as well as other patients, regardless of the difference in the diagnosis. Thus, for example, an internal nurse responds to the deliberations in the discussion. "To do or not to do? Certainly, to do! To put a ventilator on the patient who is in respiratory collapse, rather than relying on family. To rely only on clinical signs. A person in distress does not decide! I think every moment of human life has value. So, everything has to be done. There is no point in asking the patient's wishes. There is no legitimacy in giving up. Life is a supreme value. When a person is in danger of dying, it is our professional duty to do everything for the sake of saving lives. And there is no exception." (P30)

Participants who agree with the carrying out of invasive procedures among the elderly who have dementia base decisions on the existence of some guidelines from the patient himself. For example, "As long as there are no clear and written guidelines from the patient himself … it is necessary to provide full care, even invasive, even if this only prolongs life. We are not God to decide not." "As a believing Christian, I am for using ventilators. Even if it only gives a few more hours. It is possible to pray for his soul to go to heaven. For relatives, it is important ... also for the team who believes it is important. It gives time to pray." (P.17) Other caregivers maintain that "it is necessary to do everything. Life is pain. There is nothing to do. You fight until the end." (P.42).

Furthermore, many participants base their consent to carry out invasive procedures on dementia patients according to the stage of the illness. In other words, in their opinion, it is necessary to carry out invasive procedures only in the initial stages of the illness when the patient is functional and his memory is for the most part intact. "The value of life is a supreme value in our society, and therefore I would object to mercy killing, for example. But invasive actions at an advanced stage, when the patient does not understand and already does not speak, this is pure evil." Participant number 2 also expresses a similar opinion. "In an advanced stage of dementia, it is prohibited to do actions that cause suffering. With all the goodwill, this is not humane." (P.17)

Although many researchers see suffering as a main factor in the decision not to carry out invasive actions in dementia patients, some caregivers propose weighing the benefit of the care against the evaluation of the prognosis expected for the patient following care. "I am against suffering. Since generally it is clear that this does not improve the prognosis, and even does not always ensure the extension of life… so why? No! Definitely." (P.4) "I prefer that they not inflict pain… when you do something painful to a child, there is a goal – to improve something in the future… and what about the elderly? Another and another tube? For what should he continue to suffer? And he could suffer more?" (P.44)

Thus, for example, physicians dealing with lung diseases maintain that the existence of modern medical means today succeeds in extending life, even among patients with severe lung diseases. However, despite advanced medical ability, it is not possible to maintain a high quality of life for patients who need invasive or non-invasive respiratory support (Scala, 2016). The situation in additional medical fields is similar to that in the field of lung diseases. Thus, for example, in cardiology, when medical emergency decisions are routine, the main objective the physician sees are saving life and extending life and not quality (Schroder, et al., 2015).

In another group similar attitudes were seen. For example: “It is possible to do invasive things that can solve a problem, improve life… but the resuscitation, the insertion of tubes into the elderly person with advanced dementia, this is selfish, to think only about yourself. We are afraid to appear bad, in other words, to starve people… but to carry out medical procedures only to practice the performance… is this not embarrassing? Senior doctors will not let an intern insert tubes into a young mother for example… but into an elderly patient…” (P.14)

Caregivers feel considerable confusion regarding the goals of invasive procedures among the elderly in general and dementia patients in particular. They see a great subjective component of the caregivers towards the care of these patients. They express this as follows: “To see only the patient’s good… but what is good? Who knows? I don’t want to decide for anyone… I prefer clear definitions… at the moment there are no clear definitions. The feeling is that every doctor is a God for himself.” (P.17)

The attitudes of caregivers in the present work are supported in the literature. According to Scala (2016), medical decisions for the choice of invasive respiration for the most part rely on statistical data that summarize the clinical knowledge that has accumulated and been reported until now on the topic. Conversely, the patient’s desires are completely neglected, especially when talking about a situation of medical emergency. Decisions in the rest of the medical fields are made similarly. The decision to begin dialysis is made by the caregiving doctor and for the most part, is barely discussed, not with the patient himself and not with the family (Germain, 2015).

In addition, there is a lack of clarity regarding the setting of boundaries of responsibility in care and in the carrying out of invasive procedures among the population of dementia patients. Thus, “I cannot decide not to resuscitate… but I massage less strongly… do as if… it is hard to set boundaries… on the other hand, I do not want to be the one to decide. There must be a clear law. Where does the border pass between saving a life and abusing the body of somebody helpless, like an elderly dementia patient?” (P.41) In other groups, similar attitudes also arose. “They do not know when to stop… when is the age respected enough to allow someone to die quietly??? They do not know to stop… this is a mistake.” (P.38)

Additional participants also emphasize the ambiguity that exists regarding the goals of the care, the use of invasive procedures among dementia patients, and the factors considered when making decisions. A nurse expresses this, “We offer treatments that are not right for people who do not need them. This wastes resources and then both the dementia patients and others are harmed. The carrying out of procedures? The time has come to implement the approach according to which the person for whom the procedures are undertaken is found at the center. The family is very influential. The doctors… too many of them and what they do and many times it is done with injustice. There are many incorrect considerations. But is somebody asking me??? These patients are pitiful… a dementia patient becomes a tortured saint. To carry out a procedure only to give a young doctor the experience??? There is such a phenomenon… everyone is silent. I would prefer to die first.” (P.32) An intensive care nurse expresses her stance: “It is hard for me ‘to flow’ with the decision of the family or the doctors to put dementia patients on a ventilator. This is pure suffering in my opinion. But when the patient is already in intensive care … we will do everything! It is necessary to think a lot about it beforehand. Before the patient is hospitalized. A caregiver or family that brings him in is supposed to understand and know… what is the goal for which they brought him. To fight or not and what is left after this “war”? I am not God and do not want to face this decision. Life is suffering… it is suffering to see a person fight for every breath and not to help. And it is suffering to see him on a ventilator… what is better???? Each one will decide for himself… I chose to be an intensive care nurse, so as not to choose to give up, but to continue and to provide care even if these are painful actions and it appears as if they do not contribute. To continue to carry out procedures. This is also necessary for the training of the doctors. This is what there is. This is the true reality.” (P.27) Other groups also agreed with this opinion. Caregivers in other emergency wards see the making of decisions according to protocols to be more convenient, although technical, and not taking the patient, such as the dementia patient, into consideration. “There is no choice. The patient is already here. Therefore, you do technical things. And it is easier to carry out “actions of protocol”. Somebody decided, we do. That’s it.

There is no room for other considerations. There is no room for our feelings. It is easier.” (P.8) Another participant cautions against the technical approach. Alongside the lack of clarity of care goals, care of the dementia patient becomes focused on the clinical goal alone, and is distant from humane considerations. Thus, the participant says, “First of all, to examine the goal of the care… I think that the view is short-sighted… we think… that if the patient is not breathing – to put the patient on a ventilator if the patient is not urinating – then dialysis…” (P.12) “Many participants in the present research study expressed the desire not to decide regarding the carrying out of the procedure among the elderly with dementia. However, when it was necessary to adopt a position on the topic, if, for example, this were about the caregivers themselves, they objected strongly to the carrying out of invasive procedures. Thus, “… about myself, I would be insistent not to do anything to me. I do not want a life like this for myself. I have seen much of how this is … I do not want for myself a similar life. I prefer to die.” (P.25)

To practice the carrying out of a procedure, to execute a protocol, to feel comfortable as a caregiver in care – they are the many considerations of caregivers. However, they do not take into account the good of the dementia patient, when they consider carrying out invasive procedures during the medical intervention. “The considerations for carrying out the procedure are not for the good of the patient, they are foreign considerations. I do not have any influence, I do not have a say. The doctor decides – I do. Or this is how the family members wanted… for me… it is the same thing.” (P.1) In the other groups as well, similar opinions of caregivers were raised. “It's just... to disconnect a hip bone in a person who will never get up? For what??? To study? Why endanger the elderly person???” (P.13) Another group also posited similar thoughts. Thus, for example, there is an opinion “… doing procedures on 100-year-olds without any previous thinking. What is the goal? For what purpose? I am witnessing unlimited gastrostomy tubes... without thinking what the patient's potential is? What does he want... In old age homes, family members are frightened that if they do not agree to insert a feeding tube ... the elderly person will not be accepted back into the institution. The institution can also be understood. There are no people to provide care and to feed manually. It is much more convenient for caregivers, without touching, to connect 50 elderly people to feeding tubes without being in contact with them. Convenient for the staff. This is for the system. No need for 10 nurses. One is enough. The elderly man himself was not at all involved in the decision at any stage.” (P.14)

Goldberg and Altman (2014) in their research study reveal similar attitudes. In their opinion, the aging of the population and the rise in the percentage of the elderly with dementia is parallel to the shortage of caregivers which causes the carrying out of invasive procedures, such as the insertion of feeding tubes (gastrostomies), for the convenience of the caregivers in providing care. Thus, few caregivers can provide simultaneous care for a large number of patients. This style of care is very common among dementia patients (Goldberg & Altman, 2014).

Participants hold a negative attitude toward the performance of invasive procedures among dementia patients. One of them expressed the following on the issue, “I wish that in front of us was the benefit of the patient... In my experience there are various considerations, just not the benefit of the patient. Who wants resuscitation, broken ribs, or a tear in the trachea, just to extend the lifespan??? Just for them to try to prolong this life of being in bed, suffering, when you are very far from your human image??? How can you want something different for yourself and choose for the patient the exact opposite? None of us (the caregivers) wish for an end in a hospital bed... so why put in tubes, and stab helpless people to no avail??? Yes, they have dementia... Conscientiously we must be alert about the correctness of the decisions here ... After all, for the most part in advanced dementia this does not add to the prognosis.” (P.21) Many other participants do not consent to carry out life-extending invasive procedures among dementia patients. Thus, “It is frustrating. We put forth so much energy and there is no prognosis. Full gas in neutral. There is no prognosis, a waste of the staff’s emotional resources.”(P.25) Another participant also shared with her group a similar experience. “My mother, a dementia patient died a short while ago in hospital. I was insistent she not be on a ventilator. And her doctor asked me why did you bring her to the emergency room??? I did not know how to answer… something moved me to bring her … powerlessness at home versus the other family members. Who does not understand the situation? They did not explain to them how these advances … I did not think in advance … I was in a dilemma also when I was asked … suddenly I saw all that I know from internal medicine. Tubes - tracheostomy - pressure sores.... suffering... mine and hers. What life am I giving her? Why??? I was afraid that I would decide to be a nurse and not a daughter… and I decided not to put her on the ventilator! In essence… I respected her desire… that if she is not independent and something happens… I will not extend her life artificially. But professionally… it is necessary to do everything. This is my credo.” (P.29) Another opinion is similar, “There is no need to hurt. Some patients cry and scream during the operation... I get chills. There is no justification. I am in favor of palliation. A treatment that saves resources for the system and gives more humane care to the elderly. And they deserve gentle, supportive and loving care... And not the insertion of tubes for training and raising medical competence.” (P.46)

Whether the caregivers undertake an active action or not, some caregivers express objection to making decisions. In their opinion, only the patient himself can decide about leaving directives regarding different issues related to his health. For example, some nurses maintain that it is necessary to carry out invasive procedures in a dementia patient, “only if they wanted this. Not the family and not the caregivers can decide.” (P.6) Another example: “To do all that is necessary. To consider the patient’s good and not our feelings in the continuation. I am going with the doctors’ decision. But if it depended on me, I would not insert a tube into a dementia patient aged 95. It is unnecessary and leaves scars. The doctor decides… but if he would also do this and not force others, then perhaps he would give up. The family also does not have the right to decide… nobody else should decide…” (P.34)

Other caregivers who objected to the carrying out of invasive procedures among dementia patients emphasize their negative feelings that are involved in the care in which there are invasive procedures. “I would prefer not to put a patient in the terminal stage of dementia on a ventilator. This extends life, but the suffering is also extended. A terrible feeling is to carry out invasive procedures in patients who do not decide. An unresolved dilemma.” (P.18) Another participant relates a similar experience. “Does anyone see the patient as a person? Not always. Regardless of age... In patients with dementia, in my opinion, it is not good enough. Even to provide sedation before the procedure, it is necessary to grasp… one holds, the second does, for example… a needle to provide the sedation… At this time the elderly man is shouting, crying, and cursing... a terrible feeling. Years later I hear these voices ... I too have a heart.” (P.24) In other groups, similar distress of the caregivers arises. “Not to increase suffering, or yes… to carry out an invasive procedure. It depends on the person’s desire. I object to mercy killing. On the one hand… some people are confused between palliative care, like giving MO, and mercy killing. It is necessary to work on public awareness of the topic. It is difficult for me with this… with these decisions, nevertheless. Not to do anything or yes to do… it is hard.” (P.20) “I am against totally, for example, putting a dementia patient on a ventilator. I do not want to be a chunk of meat with a breathing tube in my mouth. In my opinion – only the treatment of symptoms, fever, wounds and pain, in the place of residence. I do not want to be involved in the decisions on procedures that are done forcibly. I feel bad.” (P.16) On the other hand, there are also negative emotions without adopting active actions in care. Thus, “It is hard to stand by and not do anything. This powerlessness is a terrible feeling. I prefer to intervene and to perform life-extending procedures.” (P.28) “Life is suffering, all the suffering and pain of these actions is worth the attempt to save a life.” (P.28) Another conclusion: “When Dad was aspiring in front of my eyes (spontaneous drawing of the stomach contents to the lungs) I could not see him suffocating. Where is the border? Who knows? A pacemaker? I would put in.... for a good personal feeling... what to do??? I am of the approach to do the maximum. To be technical, it's better than to feel that you are ignoring.” (P.40)

According to many researchers, it is not at all surprising that caregivers are not interested in being emotionally involved in the care of the elderly. The care of the helpless requires considerable mental resources alongside the existing emotional and physical load. Therefore, the easiest part of the care of helpless people is to adhere to the carrying out of technical tasks, by using technical professional instruments, without emotional involvement in the care. Therefore, caregivers, in their opinion, succeed in maintaining their mental well-being, despite the significant harm to the quality of the care of these patients (Nicolas, 2014).

Like other caregivers who expressed themselves in this work, nurses also in this research call on caregivers not to add to the unnecessary suffering. To convince others, there is additional experience: “Not at all costs! I say that based on experience… when you see very great suffering, not at all costs. We have at the moment a patient in the ward, autistic, helpless… who had asystole (cardiac arrest)… we did everything to him… a very difficult resuscitation… what did we do to him???? The pictures are still in my mind. I felt his pain. Until now my soul is screaming to the heavens! Why????" (P.33)

Many nurses express sorrow and frustration regarding the need to carry out invasive procedures to extend life among dementia patients. However, there is another issue up for discussion, the role of the patient's family. Thus, she expresses this: "A person needs to die and then to rot… in urgent care, the natural order of the world is harmed… a patient rots in the bed. He is exposed to pain and suffering. On a personal level… my father suffered from Alzheimer's… I knew that there was no need to put him on a ventilator. But in the moment of truth, I did not stand strong… we put him on a ventilator… it was hard to watch him suffocate, but it was harder… to stand and to hear the family shouting to the heavens that you are not doing anything. I would like to find the golden path …" (P.37)

Many other caregivers maintain that the family has an important role in the care arena. Despite negative attitudes towards certain actions in this group of patients, their professional obligation is also to care for the family members. "Suffering – this is not life! But it is more painful to keep the living people with scars that the caregivers did not do what was necessary… it is necessary to do everything. For (the people) who are living who remain after the decision… but deep inside… I will feel bad to have to intubate a terminal patient without a prognosis." (P.30)

Similar attitudes arose in other groups. In the opinion of many caregivers, the caregiver is supposed to be the advocate both for the patient and for the patient's family members. Thus, "… it is not right that everything depends on the family's decision … sometimes there is no family at all, or it cannot deal with the doctors… and the doctors just do… since everything can be excused somehow… sometimes this is just practice." (P.9)

In contrast to the prevalent opinion among caregivers that the family member's participation in the care decisions is necessary, some caregivers caution that making decisions in the elderly person's family is not always for the patient's good. There are many situations when the process of decision-making in the family entails foreign considerations, which are even contradictory to the elderly person's benefit. Hence, some caregivers object to the involvement of the elderly person's family members in his care, since they see this to be harmful to the elderly person and his care. For example: "I encounter a lot of people aged 90 who plan that they don't want tubes, do not want to be force-fed.... they ask! And people do not listen to them. Neither doctors nor family ... in general they do not listen to them! The family brings them to the hospital so they will not die at home… since they do not have somewhere to die… so they undergo abuse since nobody listens to them… we must provide care for them … treat the pain… reduce the suffering… this is respect… to be close enough to the elderly person's face to see the tears… and to act accordingly. To be attentive. What does the elderly person want? Would he want to continue the care? Or to end it?" (P.45)

There are many caregivers that express their objection regarding the involvement of the family in a decision without proper directions for it. For example: "We are to blame for all that these patients go through. We are afraid of entrenching in the family the opinion that not all they do is good like not everything that is not done is not good. I do not feel comfortable beginning invasive treatment for any kind of dementia patient. It is possible to understand that when the family wants more time with a terminally dying oncological patient… it is impossible to understand the abuse of a dementia patient… who has already been sick for years, does not say a word, and is found in bed… it is impossible to understand. Leave him alone. Enough of the phenomenon that family members compete with one another over who loves the elderly person more… it is unnecessary and brutal. It is not justified. It is possible that it is necessary to invest more in the family? To be with them? Not to be afraid to explain the difficult reality behind these invasive actions? To show them the patient on the ventilator?" (P.26) In addition, some caregivers see the families to be a factor that disrupts the care. Thus, for example: "We are busy with trying to keep the families satisfied, and not with the care, and we also do everything to flee from the responsibility to decide not to do things that are harmful to the patient. It could be that the patient's desire is different. How can a family who has not visited for two years know what is good for him??? Or decide for him????" (P.23)

Alongside the caregivers who express attitudes against the extension of suffering, some think it is correct to consider everything on its own merits. Thus, “It depends very greatly on patients and circumstances. There is no one recipe suitable for all.” (P.3) In additional groups as well, similar attitudes arise. For example, “To consider everything on its own merits… it is very difficult to stand in the hospital beside a patient who is suffocating, even if he has dementia, and not to do anything… on the other hand… when you see a patient in the advanced stage of dementia or an elderly man of 90 on a ventilation tube… and how his children, who are also old, stop coming since they cannot see this… then the question is asked, why all this? Why the ventilation or any other invasive procedure if it does not improve anything, but only extends and intensifies the existing suffering? Every case on its own merits… perhaps there is something that we do not know.” (P.9) “Every case on its own merits… not overwhelmingly. Dementia or age is not supposed to determine whether to do the procedure or not … every case on its own merits… it is necessary to learn the situation and make decisions based on the knowledge… that doesn’t happen at the moment.” (P.24).

Furthermore, caregivers emphasize the need to make individual decisions after the discussion, even when there is agreement between the caregivers. The only value in making decisions is the true good of the patient; the other considerations are supposed to be monitored in light of their being foreign to the decision-making process. “Every case on its own merits… it is preferable through reference to what the patient would want for himself. Dialysis… breaking ribs and so on… why? The patient will not get up? He will rot. In bed… and this is only for our conscience… to put the checkmark … that we have done everything. This is the caregiver’s egoism… this is not respect. This is abuse. This is for our peace, the caregivers… this is not the respect for the patient, not the ego of the caregiver. There is a point where you stop… and many times we pass the red point of lack of respect. We have desires, ego… this is not respect for the patient. This extends life… but this way???? To dispense resources without need and also to make things worse in this abundance…” (P.43)

According to Van der Dam et al. (2012), caregivers know what the best and moral way of caring for the elderly is. However, they cannot always act according to the rules of morality. This interest is especially prominent among caregivers of dementia patients. Caregivers are frequently found in an ethical crisis in light of the many caregiving decisions they make. On the one hand, there are clear professional rules that obligate a certain activity according to a high standard. However, on the other hand, in a population like patients with dementia, it is not always possible to attain the standard. In other words, even when professional behavior is carried out according to the rules and standards required of caregivers, the care outcomes do not always realize their objectives according to the initial goals of care.

The caregivers in the present research study express similar attitudes, also regarding dying with dignity. Nurses see a dignified death as a quiet death, without suffering, in a supportive, tolerant and pleasant environment, in a quiet, familiar, clean place, taking into account the elderly person's desire and the involvement of his family. This is how participant number 1 sees it, "A quiet death. When they don't cause you pain and they don't speak above your head about different unrelated issues. Personally, for me… I would prefer to die at home. In a familiar and loved place. Even if this is without the family. To die out of a sense of security and calm." "Without suffering. Actions that cause suffering that no longer have any meaning but to extend the suffering. It is important to provide care for the pain, noninvasive and calming care." (P.4)

Similar opinions also arose in the other discussion groups. "To die with dignity… first of all without invasive medical intervention. And in general... not in the hospital. This is because of the paradox… the hospital is supposed to be the most prepared for the need… to die. But in actuality… it does not know how to let the patient die with dignity. We were trained to provide care… very few of us know how to accompany the process of separation and not collapse afterward. 'Death with dignity' for me is death calmly. When you are still seen as a person. When you still have a human image… and not in a place where the staff is pressured at the bedside, to bring the next patient up from the emergency room. To die? Just not in the hospital!" (P.10) "… first of all… this should happen quietly … not in the corridor of internal medicine, as it generally happens… and not with a staff that every two minutes opens the door to see whether you have already 'finished'… not like this! But quietly. In a place you are used to. In the bed where you went to sleep. Without getting stabbed for sugar and blood pressure measurements.” (P.8)

Many caregivers noted the phenomenon that can be called “the hospital paradox”. On the one hand, the hospital is a place intended for the beginning and the end of life. However, in actuality, the hospital is a place that is not organized for death at all. Thus, there is the expression of the stance of many participants in the research study. “I return to grandmother… we took her home when it was clear that the hospital would not be contributing anything and would not allow her a quiet death … and her daughter, my aunt, was all the time beside her, and when she died, she was holding her hand… this is respectful and dignified… in the hospital… to die with dignity… first of all to stop ‘doing everything’… this does not exist. We do not stop. As if it is forbidden for us to die here. At any cost we continue.” (P.43) “… (the family) waits for the elderly person to die, looks at the clock impatiently, and plans the funeral, although he is still alive. Most of the elderly who die in the hospital do not get to die with dignity. This is my opinion. Dying with dignity is a luxury. Not everyone has it. The elderly are like… ping-pong. They don’t want him to die at home, but in the hospital, they do not have the space for this.” (P26)

In the other discussion groups, the caregivers shared thoughts with their peers regarding the human facet of the process of death. For example: “When I think about this… I think about my relatives, people… then… I wish all of us a death in dignified and respectful conditions. Quietly, privately, in a room with the family… and if there is no family, then there is a caregiver who will hold your hand and even hug you. It is easy to say what to do… I feel that this is how it is right to act. This is the essence of the profession… not once and not twice these patients die in the corridor. I personally… I am not capable of giving a hug, I cannot even display emotion. I distance myself. A kind of lock. Sometimes all I can think about... finish fast. We need the bed in the emergency room... that’s how life ends. I’m sad to be a part of that. It’s embarrassing.” (P.21) “The time has come to deal with the painful truth… there is no death with dignity for these patients, there is no respectful care of their body while they are still alive. There is no respectful care of their body after death. Nobody generally sheds a tear. Also, not the family. Since… this is not a painful loss, even for the family. We are a part of the public. The public perceives the elderly, especially the sick ones, as a burden. We are a part of the system… we preserve this embarrassing cycle…" (P.23) Similar descriptions also arose in the discussions of the other groups. "It is not possible to die with dignity and quiet, when you hear from the nurses' counter how we fight with the emergency room regarding the lack of room and when the patient is not yet dead and still takes a place that the emergency room counts on. The emergency room continues!! Pressuring to bring in the next patient. It is not logical!" (P.39)

During the discussion the question was asked: what should be done if the creation of calm and tranquility for the elderly patient who is dying is impossible? "…if the quiet and calm and other good conditions cannot be achieved, then at least put forth an effort to do all that is possible to achieve physical wellbeing and… also mental. To put forth effort for the elderly person… he deserves that we will do everything. Just like that. And I mean... give a room, not die in the hallway... you can do a lot..." (P.11)

Based on daily activity, caregivers cope with a moral dilemma regarding respect and dignity in care and death, especially among dementia patients. On the one hand, care according to the main values in modern Western society, such as autonomy, obligates the modern caregiver to act according to the patient's demands and to maintain the values important to him. On the other hand, in the case of the dementia patient, complete preservation of the value of autonomy in care may lead to neglect and harmful medical treatment or harm to the autonomy of his family members. The balance between preserving human dignity and the autonomy of the elderly person and their families, and the right to proper care of the elderly, is necessary. However, it is not always possible, especially when dealing with dementia patients. In addition, the many interpretations given to the value of autonomy in modern Western society and the lack of clarity regarding the goals in care, especially among dementia patients, create confusion and discomfort among both caregivers and dementia patients. The multiplicity of the definitions of the phenomena that appear obvious, such as dying with dignity, creates additional disruptions to the proper course of care (Smebye, et al., 2016). Thus, the findings of the present research study strengthen the deliberation and confusion characteristic of all caregivers of dementia patients.

Many caregivers emphasize the caregiver's role in the quality of the death that the elderly patient with dementia receives. "The dementia patients do not understand what is happening, and they cannot express themselves… we do not know what comes after death. And therefore, I think that there is much fear and anxiety. The dying person will not be alone! And if there is no family then we are supposed to be there. Beside him. Patiently. Until the last breath." (P.3) "… Death with dignity is the positive end to life, regardless of its length. Once the clinical instructor told me, and she was right … death may be a most positive thing, but it is always hard for those who remain." (P.5) "Separation is something very difficult at any age, and this is also a very individual process." "… even for Alzheimer's patients – separation is important. This is to be surrounded by the people the elderly person loves, even if he does not remember them. It seems to me that he feels loved... the important role of the caregiver... is to be around the elderly and protect his interests, by bringing the family closer and creating an atmosphere... also for his family." (P.6) Additional nurses support the approach according to which the caregiver has an active and essential role in the process of separation and death of the elderly person and his family. "The death of the elderly is a part of the family history. To die with dignity is to die when you love and are loved when you are in the midst of the family. Our role is to display humanity. In everything! In other words, to be at their side… especially if the family is not in the picture. "To be there". Do we still remember how to do this???? And also palliative, supportive, soft, gentle, humane care will not be detrimental." (P.17)

Many other participants adopt a similar position, according to which it is necessary to involve the family in the process of dying, especially if there are no written directives on the part of the elderly person. "Respecting the will of the family especially if there are no directives from the patient himself. This is a dignified death… to allow him to die with dignity is to release out of love… not to let him suffer. To know when to stop for the dementia patient and to place a clear boundary between the saving of life and the care of the patient and abuse. When you know to stop before the dedicated care becomes abuse – this is death with dignity. To know to sit beside him and to hold his hand. This is a skill that few of us know how to carry out." (P.29)

Like making decisions during care and carrying out invasive procedures, some respondents objected to the position according to which the main role in the process of death belongs to the families and not to the patients themselves or to the staff. Thus, “I remember an elderly person… who went through two amputations of his legs and died after arguments between the staff and his family… he simply fell between the cracks… he did not want amputations… and the family demanded it, argued with one another… he cried… and in the end it did not help, because there was no agreement between them… also much time was lost… he died suffering… when the family was arguing with one another and with the staff… then the nurses avoided caring for him… it was preferable… to give him a hand… to be with him to calm the atmosphere… this did not happen … he all the time cried… the family argued above his head, the staff let this happen… dignity? That wasn’t here at all. Sad.” (P.42)

The caregivers who participated in this research study see death as a part of holistic care, especially when referring to the elderly person with dementia. However, in their opinion, caregivers in acute hospitalization cannot allow dying in a dignified manner. For example, “An elderly person receives less respect in care, and also in death. The death of an Alzheimer’s patient is less touching and less heartbreaking than a death from cancer. For example, a death of loneliness… we, as caregivers, are less emotional. The family also generally is not present. They are all there waiting for the end. When a young patient is dying, we adjust the conditions… an Alzheimer’s patient can also die in the corridor, during a routine of the staff. Alone. Without any announcement to the family… to come to say goodbye. There is no dignity in the care of the patients, not for the caregivers and not for the patients themselves.” (P.4) Can be summarized: “When you end your life as you wanted… when strangers do not decide about you and the family members continue with your desires without other considerations… this is respect and dignity. Dying with dignity is not only dying without suffering. This is not to be a victim of heroic medicine that is worth at this moment zero. We… the nurses, are supposed to make certain of this… to enable this.” (P.14)

Many of the caregivers think that death with dignity, beyond its medical definition, is first of all the expression of the elderly person’s desire in his life. This is for most of the nurses in the research study the most important component when speaking about death with dignity. “There is a direct relationship with how the person lives his life. A person chooses how to live; he has the right to choose how to die. It is easier for the relatives to say goodbye to somebody who decides about himself and has expressed this in his life. There is no room for interpretation. Everything is clear. And therefore, to die with dignity is to die according to the directives you have left.” (P.2)

Most of the participants in the present research study agree with the position that advanced directives are important regarding death and all components of care. Moreover, the family members, lacking these advanced directives, are supposed to, under the guidance of the caregivers, make intelligent decisions regarding everything in the care and in death. However, some nurses emphasized the proportional importance of the family’s involvement in the care of the family and the care of the elderly. For example, “It is very important to involve the family… but there must be a limit! Today this limit does not exist! They (the family members) decide and we become tools in the hands of somebody… who sometimes is not at all connected to the patient. In my opinion, our role is to make the knowledge as accessible as possible to the family. And not to wait for collapse and a difficult situation. They are supposed to know beforehand, and not in the moment of truth.” (P.33) “Finding the balance between the family’s desires and the patient’s good solves many arguments. It is impossible to remove the family from the equation of care. Finding the golden path between the patient’s good, as we see it, and the family’s desire is our role. The elderly person’s family is no less important…” (P.33) In addition, many caregivers are not interested in taking the fateful decisions into their own hands. In their opinion, “It is best to reduce as much as possible the making of decisions performed by caregivers or the family … and lacking written and clear guidelines – the Court should decide. There must be a clear law that arranges the issue. My impression is that the laws that exist… for example, “the Law of the Dying Patient”, they simply do not work, are not implemented, especially when talking about the elderly.” (P.37)

Alongside the care according to needs, many caregivers ascribed importance to the topic of death. Thus, “Some of the good care of the elderly is to make certain of the directives regarding end-of-life care. To give death a place, and not to throw into the corridor and turn to treat somebody else. To stop avoiding the conversation on this topic. This is not a curse! This is a part of the care…" (P.5) "… there is nothing to be ashamed of – people die… you should update the environment on how you see things. You should think about a method according to which everyone knows what you want. Especially at a certain age. And he is lost not only at home but also in the hospital." (P.14) The importance of the early directives regarding the end of life arose also in the rest of the focus groups. Thus, "Written and proven advanced directives. To give a choice to a person, even if he came for hospitalization. The personal desire is a supreme value in the care and in death." (P.20)

Many other participants express a similar position. "It is mandatory to determine advanced directives to be conveyed also to the hospitals. The creation of a national information network is a requirement and even a shout of distress of reality. The elderly person's directives, when they are documented and transferred to the caregivers at the hospitals, also protect the caregiver who is providing care according to the elderly person's requirements and desires. Even if he already cannot communicate." (P.25) There are nurses who extend the assertion that the directives documented and conveyed to caregivers not only protect the caregivers and meet the elderly person's needs. They enable achieving uniformity of opinions in the family and reduce arguments beside the elderly person's bed. "The advanced directives will help put the patient's desire legally above the family's desire. It is required to have appropriate legislation that can protect the patients, but also the caregivers when they fight about the will that they left. And many times, the war that exists is… versus the family. The directives that the elderly person leaves, when they are known, 'destroy' arguments in the family on this issue…" (P.26) "We are afraid to speak about things that are truly important… not to be afraid to speak about death with the elderly and with his family. It is necessary not to be afraid! And we avoid… not good. This tosses us into doing things in the dark. You get locked into all sorts of mechanical things… open conversations with the family members and patients would save many resources for the system and suffering for the patients." (P.3)

Additional participants see the need for the improvement on the topic of guidance and conversations with the patients and family members. In their opinion, the giving of reliable and correct information is critical in care and is despite this awareness –

lacking. “The giving of reliable information to family members now does not exist. It is not surprising that there are arguments. There is simply a lack of information. We must converse with the family more regarding the care and programs. We must be clearer in our intentions and involve the family…” (P.24) Also, “The guidance of a family is not on paper!!! You must talk! To talk, to talk, and to talk. We do not talk with family members. True… for the most part these are unpleasant conversations… but they are important. Even after so many years of care for people, I can tell you that I do not have the experience and tools to speak with the family. Especially about unpleasant topics. But from my level of experience, I know… a conversation solves many things… and as the nurse in charge… I have influence on the staff on the matter, and also on the family… and they see me emphasize much of my time to conversations with family members. For the most part, these are not pleasant conversations… and what is troublesome is the multiplicity of conflicting demands between the caregivers and the difference in how we see the elderly person’s good, and this is what brings the family to more confusion… once the daughters of a mother with dementia told me, that she feels that the doctors and nurses are in a war… whom should she believe??? Who truly wants the patient’s good??? So… the care is not supposed to look like this from the side…” (P.29)

The agreement in the literature regarding the importance of planning life is prevalent, especially when talking about the end of life. Thus, the absence of the construction of clear directives at the right time leaves important decisions in the hands of the people who act according to personal principles and values that are not related to the elderly person’s desires or needs. The topic has become critical, especially when referring to dementia patients in the advanced stages of the disease (Bollig, et al., 2016). Thus, the attitudes of the participants in the present research are not at all surprising, according to which the caregivers did not know with certainty the patient’s real desire regarding the end of life and medical procedures to save life. Consequently, caregivers and/or family members decide according to a personal system of values. To solve the issue and to achieve the best for patients, caregivers must initiate cooperation with the elderly person and his family members as soon as possible, preferably close to the diagnosis of dementia or even earlier (Dening, et al., 2012). However, more than 90%

of elderly people do not speak about end-of-life plans. This avoidance is maintained by many caregivers who although they know how important it is to have this discussion avoid topics associated with the end of life, especially with their elderly patients (Germain, 2015). The attitudes of the caregivers who participated in the present research study also support these findings.

According to many caregivers, the gap created between the elderly and patients in general exists in most of the medical domains. This is what participant number 39 asserts, “Everyone deserves a similar attitude… a good attitude. And I see the expression in the reduction of the gap between patients in a terminal situation and the elderly with dementia. Unfortunately, these elderly patients, who are also found in a terminal stage of the illness, do not at all receive a similar reference to their situation.” In other discussion groups the participants expressed a similar attitude. According to participant number 41, “Today there is no hospice for dementia patients, like, for example, there is for the oncology patients. The time has come to construct such frameworks also for dementia patients. And I do not speak about regular old age homes. It is important to enable a framework, such as hospices, for the elderly of the same level and accessibility, as for oncology patients.”

Discrimination in the health system is not a new topic under discussion. Its origin is drawn from social inequality and the health system preserves the phenomenon and reinforces it. The strongest basis in society for inequality is socioeconomic status, while age exacerbates the discrimination that is created and makes the elderly into a weak population, socially rejected and discriminated against, in all social areas including medical care. The phenomenon encompasses many countries in modern Western society. Cardiology, respiration, nephrology – all these and many additional other medical domains show clear findings regarding the difference in making medical decisions, care, and medical services between young people and the elderly (Schroder, Fink, Schumann, Moor, & Plehn, 2015; White, 2014). Thus, the feelings of caregivers in the present research study regarding the existence of discrimination in Israel against the elderly in general and dementia patients in particular are not surprising.

During the discussions in the focus group in the present work, many caregivers brought their feelings up regarding the significant decline in the respect for the elderly in society. In their words, the elderly have lost their social value, and the public addresses them as a burden. The caregivers see the negative attitude towards the elderly prevalent today in society, the main difficulty in providing care for the elderly at the level of the health system in general and on the level of the caregiver in particular. Thus, "It is important to enroot respect for the elderly in the education system. In our modern society, they have lost their value… once the life wisdom they had was important. Today it appears that the Internet knows better than they do, and old people are no longer needed. The elderly have lost their human value. The young people are reluctant to take care of them... or even to come into contact with them." (P.1) There is a nurse who believes that the difficulties with which the caregivers cope begin in social values. She holds that "this is a social problem… they do not know what to do with them. They no longer constitute the light of knowledge and wisdom like they once did… more and more they are perceived as a burden… perhaps here is the problem?" (P.9) "There is no doubt that the education of the public to accept the elderly person is important. Perhaps this will change the nature of the young caregiver? Now, the care of the elderly is not attractive, the elderly person himself is not attractive. Who wants to learn so many years to come to work without meaning? We all learned to save lives, no? And not to sit and hold the hand of an old person who is going to die from old age… this is true… there are no values to the respect of old age… the young generation no longer esteems wisdom, there is Google! It is necessary to entrench values of respect for the elderly person. There is a decline of these values in modern Western society." (P.19) "The cultivation of values in society is a smart thing… and takes time. We must increase public awareness of the elderly and dementia. And in general, towards old age." (P.26)

Another participant brings a similar point of view. "There is no longer any value for the elderly in society, as a result, the elderly with dementia lack human value at all... what happens to us??? In my opinion, nothing will change in the health care system until we increase the human value of our seniors in society." (P.2) "Respect for the elderly? These are just words ...". "More and more prominent... when an old man dies - a nurse closes his eyes, not the family. To increase the value of old age in society is very important... the question is whether it is enough when the emotion is not involved and everyone takes care of himself?" (P.26)

Alongside the agreement among caregivers regarding the need to reinforce social values related to the elderly, some caregivers have expressed hesitation regarding the choice of values themselves. In their opinion, today the voice of the elderly is not heard by the public at all. Thus, caregivers cast doubt on the correctness of the chosen values. "Nobody knows… what exactly will create a better future for the elderly and especially for the dementia patients… does the approach of the value of life preferable to the approach of 'so they won't suffer'? Who knows? Who will take responsibility for the decision? Has somebody asked the elderly themselves?" (P.28)

Many caregivers in the present research study argue that a change in the health system begins from a change in society. One participant brings this to the discussion: "We must return to the starting point… and enroot the concept of 'aging with dignity' which today has lost its value." (P.5) Another nurse also sees the importance of raising the value of the elderly in society as an important beginning in the building of the appropriate care of the elderly. She expresses this, "It is important, to begin with the improvement of the status of the elderly person in our society. To increase the professional prestige of the caregiver? It is impossible out of contempt for the elderly.... the elderly are held in contempt and as a result, also those who care for them." (P.35)

According to many caregivers, the definition of social values constitutes a necessary basis for the change in the status of both the elderly person and the caregiver. Therefore, action is required that will begin with legislation which will define the obligations and rights of the caregiver in the care of the elderly. Thus, "The redefinition of the value of the 'sanctity of life' and a 'death with dignity' will provide an opportunity to end subjective interpretation of caregivers and family members as one of the many topics related to care. Clear rules on the topic are required. The legal section defines the caregiver's duties, and on the other hand, will protect the caregiver especially when family members change their minds regarding end-of-life care. We (the caregivers) are afraid of the families and their lawsuits. And because of this… we have forgotten that we are supposed to be the advocate of the elderly. The dead – do not sue! But the families – they do! Instead of doing professional things, like being beside the patient… we fill equipment in drawers. Each one is supposed to carry out his professional duty… nurses are supposed to engage in care and not in cleaning, arrangement of the equipment, security… when we stop being secretaries and all the other things… the quality of the care will rise." (P.6)

The multiplicity of tasks, load, and lengthy hours are seen to be a significant detriment to caregivers' activity in the care. Thus, "It is clear why there is no emotional investment in the care of the elderly and the alienation and distance of the staff in the care are noticeable… there is no time for emotions in the care. Many demands, and many managers in your head, who do not understand much of our work. Dealing with things that are time-consuming and do not belong in care, such as computer work and never-ending reports." (P.7) Other research participants support this argument and even share with their group the feelings that arise in the care. In their words, the many tasks, and the great emotional, physical and time load that characterize the care of the patients for the most part fit in with the harmful, contemptuous and even humiliating attitude on the part of the superiors. The caregivers in the research express this, "It is hard during the shift to raise your head from the mechanical tasks that do not end until you see in front of you the patient's health situation, his illness, and not the patient himself. We are a few versus many… we do not receive a respectful attitude on the part of our superiors… it is clear that when there is a crisis, the first who suffers is helpless. And since there are all the time crises… certain groups of patients suffer the most… including the elderly… and especially the elderly with dementia. I, as a nurse, feel like a punching bag of the Ministry of Health, when I receive minimum wage. It is clear that to provide a humane attitude… and what is certain – to be the advocate of somebody, when I am harmed, myself and I do not have an advocate – it is impossible." (P.9) Other caregivers require the improvement of the caregivers' conditions. "This is a feeling of working in a factory, in a production line… all the time you run. Without drinking, without eating, without… restrooms. It does not end! How is it possible not to race, when there is ten times more than you can do????" (P.44) "First of all, it is necessary to create humane conditions for caregivers. Somebody examined whether we have a corner to eat at in the ward? No! We do not have in the ward even a place to shower in after the work day… did you know???? ‘Beaten’– gives a similar attitude.” (P.42)

Also, “The caregivers’ conditions must be improved. We are not slaves! In many places where I worked the attitude was humiliating and not respectful, minimum wage, and requirements were as if I had sold my soul. It’s not at all right! It is not an appropriate attitude and it is no longer possible to continue like this.” (P.47) “I would like to feel that my work is valued, and me too… I would be happy for respectful relations and not relations of ‘you have no choice’. I want to work when I am seen when I stop being transparent. The work did not begin to be easier… but I can do it better. I will put in more of myself, from my heart. And also … I will be happy with fewer work hours or a fair interval between shifts… so that I can rehabilitate my energies. It is necessary to start from something… why not begin from seeing me, a nurse, a person? A person who needs food, drink, rest and sleep. We are not machines and are not slaves.” (P.46) Similar voices also arise in the rest of the discussion groups: “A feeling of esteem that you receive gives a possibility of forgetting the anxiety, despair, and frustration. Esteem on the part of the superiors??? It does not exist in the system. These are rare luxuries… we are transparent. We lack a voice and power.” (P.28)

Furthermore, “the time has come to care for the caregiver. We are the most neglected … the salary is not commensurate with the number of demands and scope of the responsibility. And also… and perhaps the most important from my perspective… to begin to choose more meticulously who is caring for people… to provide respect for the working person. To toss those who are ruining our good name. And especially among those who care for the elderly… a random caregiver – is a dangerous caregiver! Then… the time has come to improve the conditions of employment of caregivers of the elderly. Not only to give them conditions, like the possibility of leaving for courses but to allow the use of this… a laughable salary and the tuition of the courses is sky-high… and also in actuality they do not allow them to leave… so how do you bridge this???” (P.11) Another similar position: “Humiliated slaves do not provide respectful and sensitive care … they must learn that it is necessary to pay what is needed and to improve for us the working conditions.” (P.13) In other discussion groups as well, the ease at which random people come to care for the elderly is not acceptable. “Better filtering between the caregivers is the most important. But in actuality, there is nothing to choose from… a quality and skilled caregiver does not come to care for an old person. Thus, a poor level of caregivers is created. People who are not desired in any place or who lack skill are found at the start of their path. There is nothing to choose from. They… are technical. They come to pass the time and get a salary. People like this are not suitable for care in general and certainly not for the care of the elderly. More and more unsuitable people are coming to care. This must be stopped. This issue is very prominent in the field of old age. I find it sad.” (P36) “It is necessary to prefer caregivers with a high EQ (Emotional Intelligence). The improvement of conditions and salary may help in the filtering of better caregivers for the care of the elderly. The doctors too… there are those who for simple practice put on ventilators everything that moves, without consideration of anything. The caregiver stopped being humane. It is most common among the elderly… and because there is no prestige in the care of the elderly, temporary and random people come here. They pass the time…” (P.37) “…don’t accept to this work random people. This poisons the general work and the rest of the staff!” (P.45)

The lack of caregivers in the health system to perform routine work, such as position changes, causes the health system to recruit caregivers without checking their suitability for this job, thus reducing the emotional aspect of daily care (Marcella & Kelley, 2015). In addition, the necessity of performing ordinary daily tasks in the care of dementia patients, together with the lack of skilled caregivers, reduces the care to simple physical work, without a human component (Martin, et al., 2016). The caregiver’s work, especially among dementia patients who are elderly, is known to be physically and mentally difficult. Therefore, when a caregiver is under emotional and physical load, when he is burned out in his work, his care becomes more technical and less sensitive (Arcand, End-of-life issues in advanced dementia. Part 1: goals of care, decision-making process, and family education, 2015). Moreover, “being humane”, is also getting a humane attitude back. Thus, a caregiver who is treated with respect and appreciation by the system can provide similar treatment to his patients, despite the complexity involved in the care (Pohontsch, et al., 2017).

"Let's get out of the comfort zone of silence and understand that the situation will not change without the addition of standards and adequate wages for the workers with the elderly. This is a necessary condition but not the only one. We must completely change the treatment of the elderly. That is to say, to provide care according to needs and not out of 'here you have everything we know how to do'. To give all care, even acute, in one place, taking into account the special situation of old age. Just as pediatric medicine is not 'medicine for little adults', so is the medicine of the elderly is not medicine like everything else." (P.26)

Alongside an adequate salary and better conditions in their work, caregivers require appropriate training and updating of skills and current knowledge regarding the care of the elderly. Thus, "Most of us here are nurses with experience… everything is experienced… certainly we made mistakes. There is still much to learn, in my opinion. It is important to train us better. I did not undergo adequate training in gerontology and certainly not in geriatrics… from this it is necessary to begin. This certainly will improve the care of the elderly. When you do something from 'it seems to me', this never looks good…" (P.13)

"Especially they lack the tools to understand the patients with dementia. And also, and perhaps most importantly, the time has come to bring down the load, this also harms my ability to keep up-to-date and to learn. And as a result, it also harms the quality of the care. The load of the work placed on me harms more the dementia patients. They are the last in the care. When I am supposed to put forth effort to understand, to put forth effort to give emotion, during the running at work and from the tools that I do not have… no, thanks! I remain in my comfort zone – 'mechanical' care– to begin and to end the shift." (P.19)

"They lack tools and skills… I think that the development of communication skills with the family of an elderly person in the final stage of life may give most of us confidence in the care…" (P.26) In the opinion of other caregivers, communication with family members during the care is a significant part that contributes to the nature of the care, especially when talking about the care of the elderly. "Family involvement in care is very important. And we are the main mediator. We must ask ourselves and the family what can improve the care of these patients? To study the topic and implement it immediately.” (P.16) Other caregivers see the situation similarly. “It is necessary to place a significant emphasis on the relations with the family… also to surround them with the concern they require. We must be, to improve the ability to involve the family… To find a comfortable approach good for them. This way certainly it will be good for the elderly.” (P.17)

The development of different skills and the updating of professional knowledge are important factors. They take time and do not improve the situation today. In the opinion of the many caregivers who participated in the present research, the giving of additional authorities and the extension of existing authorities may significantly better the elderly people’s situation during care. Thus, “The time has come to broaden the nurses’ authority. We are there. In the arena… many times without medical presence. It is necessary to permit the nurse to give painkillers, for example. To shorten the time between the patient’s acceptance to the ward and providing minimal care. Today from the moment of arrival to the ward to the providing of treatment for pain long hours pass. And all this time we hear shouts and crying… and the doctor is not found there… if I were permitted to give something before the doctor comes, I could have made the reality of the same elderly person better.” (P.16)

There are many similar attitudes. “The authority of the nurses must be immediately extended. The physicians are not there and without the directive to give medications I am locked in place. In my opinion, authorities improve the quality of care... simply reducing suffering. To study for 4 years to run after the doctors???? It's a waste of the human resources already there, like nurses who are present there... on the other hand, the doctors are not there, to hear how they cry...” (P.20)

The treatment of pain is known in the literature to be suboptimal among the elderly, especially among dementia patients. Moreover, one of the main difficulties in finding an effective solution regarding pain management in this population is the lack of reliable information, since when carrying out research studies on this topic the population of dementia patients is not included (Smebye, et al., 2016).

The reduction of the load at work and quality professional training at an appropriate cost are only a small part of the process of improvement of the situation of the care of the elderly. For example, “… I would like support for the caregiving staff. Our mental tiredness and our exhaustion are simply already at peaks… there are no tools in the professional backpack. There are insufficient communication skills with these patients. And there must indeed be higher salaries and better professional training, which is supposed to also include the improvement of the EQ skills. But how to begin? Perhaps it is necessary to raise our professional prestige? Do you want the good of the patient????? It is necessary to create a supportive framework for patients and caregivers through the addition of resources to the health system…" (P.15) Also other nurses demand emotional support: "We do work that nobody wants to do. Not even the relatives. People bring foreigners to care for our elderly… We are found in emotionally and physically difficult situations… there must be emotional care for the staff. And not only in a time of pandemic. I am going around with the feeling of guilt – "I did not finish", "I did not do", "I am not good enough" … the salary is not enough. I need more vacations! I do not manage to charge batteries for the next day… like many others… like… all of us… I am not able to provide humane care based on emotions. I do not get to breathe. I have a right to freedom… in actuality, I am not allowed to go, since there is nobody who will work… I am fed up. A feeling of unresponsiveness and endless despair." (P.19) "The improvement of conditions and an adequate salary for the caregivers of the elderly. This is mandatory. The limitation of the work hours… this is the minimum that is possible and necessary to do for the caregiver. Most of us to reach pension… we die first… how is it possible to proclaim on the banner 'proper care of the elderly' if there is no proper care for the caregiver?" (P.14) Other participants expressed a similar stance. "Burnout and powerlessness… there is no possibility for sensitivity, there is no time to provide sensitive care, and there is a load of tasks. And there is no filling of the batteries of the staff in time. We should start taking care of the health of the nurse who is caring for the elderly. There is compassion exhaustion. 'The fuses are shorting.' It is impossible to go on. There are many 'flat tires' (unplanned absences). The situation is getting worse in front of our eyes. I would happily leave here... as soon as I have something else to make a living from. Embarrassing." (P.5)

This research study explores the dynamics of the opinions of caregivers towards elderly patients, particularly those with dementia, in the Israeli healthcare system. The main positive finding is that nurses believe Israel offers high-quality medical care, with advanced technology and well-trained professionals. However, there are a few negative opinions on the care of the elderly. In general, caregivers perceive the care of the elderly, especially dementia patients, as subpar, impersonal, and not tailored to their specific needs. Furthermore, in nurses' opinions, frequent use of physical restraints and lack of emotional connection are highlighted as negative aspects. Also, the physical environment of care facilities is often described as inadequate and depressing. Additionally, caregivers feel a lack of respect for themselves and the elderly patients, and they believe society undervalues the elderly and views them as a burden.

The nurses in this study desired some improvements in care. Thus, they emphasize the importance of a holistic approach that considers the emotional and social needs of patients alongside medical care. And they advocate for more compassionate and respectful interactions with patients. Also, in nurses' opinions, the creation of dementia-specific care units with appropriate staffing and environment is suggested and they seek better working conditions and support to combat burnout.

Another important finding is that there are differing opinions on the use of invasive procedures for dementia patients. Some prioritize the sanctity of life and believe everything should be done to save a life, regardless of diagnosis or prognosis. Others emphasize considering the patient's wishes, the stage of the illness, and the potential for suffering when making decisions about invasive procedures. Some caregivers advocate for palliative care that focuses on comfort and dignity rather than prolonging life at all costs.

Overall, the study reveals a gap between the caregivers' perception of high-quality general medical care and the care they witness for the elderly, particularly those with dementia. The caregivers call for a more humane, patient-centered approach that respects the dignity of the elderly and improves their overall well-being.

6. More Than Bodies: Rehumanizing Care for Our Aging Population. (Personal opinion):

Rehabilitation after prolonged mechanical ventilation. A connection to reality.

More than two decades ago, a single encounter etched itself into my memory. As a young nurse in a gastroenterology unit, I was tasked with preparing a feeding tube insertion for a 92-year-old Holocaust survivor with dementia.

Accompanying documents revealed that the man's daughter was a frail woman battling cancer at 72. His diagnosis had thrust him into an institution years prior. Now, with his refusal to eat and take medication, a feeding tube was deemed the solution.

The doctor explained the procedure, its risks, and complications. The daughter, overwhelmed with grief, signed the consent, wrestling with the internal conflict of "brightening" her father's life through artificial means. Her own frailty and dependence on a caretaker due to her illness painted a bleak picture.

Simulation training, during the current work.

Even today, I recall the long moments spent holding his hand after the procedure. A silent reassurance that he wasn't alone in that sterile room. Tragically, half a year later, the daughter succumbed to her illness. Two years followed before the father passed away too. This heartbreaking event became a catalyst. Over the next 12 years, I witnessed countless similar scenarios – hundreds of demented patients subjected to feeding tubes, often a solution driven by a lack of adequate caregiving resources.

These patients are not just numbers on a chart. I remember their heart-wrenching cries during anesthesia, the desperate pleas to be left alone, the fear etched on their faces. Many lacked families, relying on court-appointed guardians who, lacking full understanding, signed consent forms for procedures with unknown risks.

We, the medical staff, became unwitting participants in this cycle, burdened by the ethical and emotional weight of these actions. It wasn't the kind of care I envisioned when I became a nurse. My calling was to heal and comfort the sick, not to prioritize the "convenience" of overwhelmed caregivers in a failing system.

Integration of therapy dogs in the care of the elderly.

We need to ask ourselves, "Have we truly looked into the eyes of these patients?" Do we see them solely as bodies requiring a specific action, a bed to occupy, or a billing code to generate? What about the man's "greatness," his legacy, his life story beyond his current state?

Daily ending life care.

The daily reality for geriatric nurses is a far cry from what they need. We witness patients relegated to hallways instead of proper rooms. We juggle an overwhelming 8 to 14 patients at a time, their unique needs lost in the whirlwind. We yearn to offer emotional support to families facing loss, but our time is a luxury we can rarely afford. The physical and emotional toll is immense, leaving us drained and unable to properly recharge.

The current system is failing us all – patients, families and healthcare professionals. We need real, tangible change in geriatric care, change that starts by valuing and addressing the human element at the heart of it all.

This is a call to action. Let's stop with piecemeal solutions and work towards a comprehensive system that prioritizes both quality care and the well-being of those who provide it. Let's honor the humanity of our aging population, ensuring their final chapters are filled with dignity, respect, and genuine care.

Treatment of a ventilated elderly person, according to quality standards.

7. Conclusions:

The recruitment of participants for the present research study was carried out at the time of the COVID-19 pandemic in the period between November 2020 and February 2021. The issue of the pandemic made it significantly more difficult to recruit the participants. Thus, following the considerable load placed on the shoulders of medical staff in hospitals and medical institutions, the discussions in focus groups were conveyed to the ZOOM platform. Doctors, nurses, aides, social workers and religious people were invited to participate in the research study. However, in actuality, only nurses and nurses' assistants participated. In contrast to the physicians, many of the nurses not only expressed their willingness to participate in the research study but also sought to create a relationship after the focus group, since they felt a need to continue to discuss different issues in their work, which are not related to the topic of the present research study. It is possible that the pandemic not only influenced the composition of the participants who were recruited but also caused the nurses to have some sort of openness that would not have existed without the events that characterized the period. It is reasonable to assume that the pandemic changed the research, but at the moment it is not possible to evaluate the manner and magnitude of this influence.

Many of the research participants maintained that the health system in Israel not only is one of the most accessible in the world to the public at large but also can provide medical services at a high level. However, when the topic of the quality of the care of the elderly in general and the care of the elderly who have dementia, in particular, was brought up for discussion, the caregivers expressed their negative opinions on this topic. In other words, the main position of the research participants is that the elderly do not receive appropriate care. Moreover, the manner of the care provided for them harms their dignity, does not suit their needs, and does not at all take into consideration their desires. In addition, the care of dementia patients is even worse than the care of the healthy elderly population or the elderly with other chronic illnesses. Nurses reported that they suffer from a lack of instruments, skills, and sometimes even the desire to care for people who have dementia, especially when they are in the final stage of their illness. Furthermore, when the respondents were asked to explain the situation that is created, most of them spoke about the lack of purpose in the treatment of elderly people with dementia, because they see the prolonging of life as having the same value as the prolonging of suffering and thus see the care as a violation of human dignity and freedom and even a waste of the system’s limited and valuable resources. In addition, for the nurses, the care of the elderly especially the elderly with dementia is care that nobody wants to do. This is the field that is least desired and least fashionable, to the point that an impression is created in the public of workers and general society that one who comes to care for the elderly and remains to work did not succeed in any other medical field, such as maternity or oncology. This is care without a feeling of heroism and satisfaction. Thus, many random and temporary people come to the field and exacerbate the situation for caregivers who work out of a belief that this is a way to act out of good personal will. Also, the disrespectful attitude towards the elderly in society in general and hospitals in particular conveys a similar attitude towards their caregivers. And, from the respondents’ perspective, the situation is worsened following the emptying of the mental batteries and the lack of time to charge them, a salary unsuited to the work, multiplicity of tasks, many physical and mental difficulties in care, lack of physical resources for care (such as bandages and diapers), and so on. Caregivers during the discussions demanded an immediate change in their situation both on the level of society and on the level of the system. However, the research participants mapped possible changes on the level of the system alone. It appears that the research should be extended on this topic among caregivers for the mapping of factors on the level of society that may bring about the desired changes and the building of intervention programs for medical staff.

When discussing the quality of care, it is not possible to ignore the quality of life. In the present research study, many caregivers saw decisive importance in the continuity of the preservation of the quality of care during old age, especially when the elderly person needs medical treatments or suffers from dementia and lives in an institution. However, among the caregivers, there was no consensus about the formation of a uniform definition of quality care during old age. Nonetheless, most of the caregivers saw the quality of life during old age as a consideration of their desires and staying in a loving and supportive family. Regarding elderly patients with dementia, they expressed the desire to take into account their desires if they expressed them before the progression of the disease. During the discussion on the topic of the quality of care among the elderly, the research participants addressed the poor quality of care among the elderly in general and among the elderly with dementia in particular. Moreover, caregivers in the research study noted that most dementia patients suffer from poor quality of life which begins with inadequate care that does not meet their needs. Thus, for example, caregivers who participated in the research study maintain that during the care of these patients in different institutions, there are long periods in which they suffer from a lack of basic resources, such as diapers, hygiene products and towels. Furthermore, most of the institutions for the care of these patients do not put at the workers' disposal innovative means for the care of these patients, such as levers for the safe and easy lifting of the patient, pillows to prevent pressure sores, and so on. In addition, some caregivers asserted that the quality of the care of patients during the care or stay in the institution depended on or at least was influenced by the quality of the caregivers' working conditions. In other words, in the respondents' opinion, the caregivers who suffer from inferior conditions in their work cannot provide quality care or see to the appropriate quality of care for the elderly. When respondents spoke about inferior conditions in their work, they addressed different factors, both physical and mental. Prominent factors included the lack of orderly and clean showers and/or restrooms, the lack of a break for eating and drinking, the harmful and humiliating attitude on the part of superiors, poor social conditions, the low salary that does not suit the needs of the caregiver's work, and lack of respect for the social conditions as determined by law.

In the discussion regarding the invasive actions carried out among the elderly, the opinions of the caregivers in the research study were divided into two. One group of caregivers believed that to save life it is necessary to fight with all force and perform all necessary actions possible. Other caregivers held that among the elderly it is necessary to carry out only the actions that will preserve or improve the existing quality of life. Otherwise, no invasive actions of any type should be carried out. In contrast, when the caregivers were asked about performing invasive actions among dementia patients, the research participants unanimously objected to carrying out such actions, especially actions like gastrostomy that extend a life of suffering for the elderly person with dementia and are done only for the caregivers' convenience. It should be noted that most of the caregivers expressed a positive opinion regarding the carrying out of invasive actions to save the elderly patient's life. Nevertheless, they expressed strong opposition to performing actions like the insertion of a breathing tube in their relatives and would also object to this for themselves. The research participants also maintained that they feel confused following the steps that should be undertaken toward action or a decision on an action. Thus, for example, there is a multiplicity of conflicting and yet simultaneously mandatory guidelines and sometimes there are directives coming from the elderly that are not taken into consideration. Consequently, the caregivers who participated in the present research study have negative emotions, such as feelings of guilt, frustration and lack of trust in the system where they work. Furthermore, following the carrying out of invasive actions against the directives of the elderly patients, some of the participants in the research study felt that they were criminals who were breaking the law. These negative feelings cause the caregivers to think about leaving their workplace, to prevent carrying out work that contravenes moral values. In addition, the research participants emphasized the lack of end-of-life directives coming from the elderly person himself. In their opinion, the issue causes many arguments in the families of the elderly and/or arguments between the caregiving staff and the family members. Furthermore, there are isolated situations in which the elderly person leaves directives but they reach the hospital later, and some actions had already been carried out when the staff did not know about the existence of these directives. The issue causes discomfort among caregivers. Moreover, the caregiving staff participating in the present research study expressed their desire not to make decisions on controversial issues, such as the care of the elderly. They emphasized that from their experience the courts do not help sufficiently. In their opinion, laws, rules and procedures that can address this issue are lacking. Additionally, respondents reported that in the field an impression was created of a short-term view of the topic of the carrying out of invasive actions in the elderly. The decisions are made under the pressure of the families, far from clinical considerations, or while setting goals that are false, unclear or unsuited to the elderly. The general feeling prevalent among the caregivers in the research is the feeling of chaos, unmethodical decisions, and abandonment of both the patient and the caregiver in this situation. Also, it appears that not every action undertaken is performed for the patient’s good but out of different considerations, some unethical, some immoral, and some even detrimental.

When the topic of old age and care of the elderly was presented for discussion, the concept of ‘dying with dignity’, which constitutes in the opinion of many caregivers a pillar in the care of the elderly, was brought up. Dying with dignity for the caregivers is a quiet death, without shouting and hospital noise. If possible, this should happen at home, in a place that the elderly person finds familiar, pleasant and loved. If this is not possible and the elderly person must end his life in hospital, then the room should be separate and quiet, with humane physical conditions, suited to this difficult situation. It is preferable that the patient be amongst family or loved people he has known in his life. If the person does not have a family to be with him, then staff members, preferably a nurse, should sit beside him and hold his hand, patiently, peacefully and quietly. In addition, the caregivers demanded that the elderly person not suffer. In other words, there must be intelligent and proper care of pain, without unnecessary invasive actions; there must be supportive, gentle care for the achievement of the maximum quality and comfort for the elderly person whose life is ending. Furthermore, death with dignity is a situation that is given time, space and emotional support for the elderly person and his family. The end of life is supposed to occur with dignity and patience, through the execution of a written will (if there is one) or through the person's ethical code and according to the elderly person's preferences.

If the situation is analyzed according to the integration of the two models that were presented in this research work, the ABC Model and the Model of Karasek, then it is possible to see that caregivers who begin to care for the elderly do this when their emotions and thoughts are negative. Many respondents in this work maintain that to care for the elderly "is not an act of courage" and the field of the care of the elderly is not fashionable. Most of them expressed the willingness to leave if only they had a better place. In addition, a person who works in actuality with the elderly in general and with dementia patients, in particular, feels that he is unappreciated, is performing unnecessary routine work without an appropriate purpose, and is subject to mockery and contempt on the part of colleagues. Thus, the negative emotions created during the care along with the negative actions and thoughts create negative attitudes regarding the elderly and dementia patients. Furthermore, when the many demands of the role of the caregiver (such as the many hours of mentally and physically difficult work, the load of tasks, etc.) significantly exceed the resources that this role provides, the caregiver may accumulate negative general outcomes. According to the integration of the models, it is possible to predict that the caregivers who accumulate over time negative outcomes without intervention to change their thoughts and emotions provide the elderly with care that is of less quality than they could have done. The present research study presents many examples that support this prediction. For example, "humiliated slaves do not provide dignified and sensitive care …" (P,13)

For an in-depth examination of the efficacy of the integrated model presented in this research work for the prediction of the quality of the care, a research study should be performed that will include additional medical professional practitioners, other than nurses, such as doctors and social workers. In addition, it is necessary to extend the research study and examine the topic among a larger population of nurses who provide care for elderly dementia patients in different institutions.

In conclusion, the research sheds light on the challenges faced by caregivers in providing quality care for the elderly, particularly those with dementia. The study highlights the need for immediate changes both at the systemic and societal levels to address the deficiencies in care provision. As evidenced by the research participants' experiences and perspectives, there is a pressing demand for improved working conditions, adequate resources, and respect for the dignity and preferences of the elderly patients.

Recommendations for future research include expanding the participant pool to include a diverse range of medical professionals beyond nurses, such as doctors and social workers. This broader perspective can offer valuable insights into the multifaceted challenges faced in elderly care. Additionally, examining the topic among a larger population of nurses caring for elderly dementia patients in various institutions can provide a comprehensive understanding of the issues at hand.

Furthermore, an in-depth exploration of the efficacy of the integrated models, the ABC Model and the Model of Karasek, in predicting care quality is warranted. By evaluating the impact of caregivers' emotions and attitudes on the care they provide, interventions can be designed to enhance the quality of care for elderly patients.

In essence, addressing the intricate issues surrounding elderly care requires a collaborative effort involving caregivers, healthcare professionals, policymakers and society at large. Building on the insights gathered from this research, it is imperative to develop targeted intervention programs and systemic changes to ensure dignified and compassionate care for the elderly population, especially those with dementia.

8. Suggestions for improving the quality of care for elderly people with dementia:

Some researchers are proposing health promotion strategies to halt or even prevent the onset of the disease, such as moderate, regular physical activity adapted to the elderly population. Of all of the strategies currently offered for dealing with dementia, physical activity is a financially viable, practical, easy-to-implement strategy, adaptable to the general public. For example, as a result of the proven benefit of physical activity, the World Health Organization recommends that adults aged 18-64 exercise at least 150 minutes a week to achieve cardiovascular endurance, improve bone strength, and reduce disorders resulting in a lack of communication (such as depression), although today, unfortunately, dementia is not yet included in physical activity-related illnesses. Carrying out additional research and intervention programs for people, to assess the effectiveness of physical activity in the elderly may not only contribute to physical well-being in the elderly but also prevent the escalation of dementia (Ginis, et al., 2017). Preventing illness through physical activity is a critical aspect of healthcare, but implementing it as a policy specifically to prevent the rise in the number of elderly patients with dementia may not be entirely practical at present. While physical activity has been shown to have numerous benefits for overall health and can potentially reduce the risk of developing dementia, there are several challenges in implementing this on a large scale for the elderly population. Firstly, it is important to recognize that dementia is a complex condition with various risk factors, and physical activity alone may not be sufficient to prevent its onset. While exercise can help improve cognitive function and slow down the progression of the disease in some cases, genetics, age, and other factors also play a significant role in the development of dementia.

Additionally, many elderly individuals may have physical limitations or chronic health conditions that make it difficult for them to engage in regular physical activity. This can make it challenging to implement a policy that mandates exercise for this population, as it may not be feasible or safe for everyone.

Instead of solely focusing on physical activity as a preventative measure for dementia, a more holistic approach to promoting brain health and cognitive function in the elderly may be more effective. This could include initiatives such as promoting a healthy diet, social engagement, mental stimulation and regular medical check-ups to identify and address any potential risk factors for dementia.

In conclusion, while physical activity is an important component of preventing illness, including dementia, implementing it as a policy specifically for the elderly population may not be practical or effective at present. A more comprehensive approach to promoting brain health and overall well-being in the elderly may be a more feasible and beneficial way to address the rise in cases of dementia. Building a therapeutic framework that includes a variety of services for the elderly is the most feasible alternative (Malak, et al, 2016; Karg, et al, 2018).

The integration of Information and Communication Technology (ICT) and new devices into the lives of the elderly, especially with dementia, can significantly enhance their quality of life. One of the key benefits is the prevention of loneliness and isolation. Social networking sites or specially designed apps tailored for older adults enable easy communication with family, friends, and peers. Improved mental health is another important outcome of ICT adoption. Regular social engagement through digital tools can help them combat depression, which is common among early dementia. Additionally, access to games, puzzles, and learning opportunities on digital platforms provides cognitive stimulation, promoting mental agility and overall well-being. The use of ICT also enhances physical and emotional well-being. Health-related apps may remind users to take medications, stay hydrated, or engage in physical activities, encouraging a healthier lifestyle. Furthermore, ICT tools empower the elderly by promoting independence and building confidence. Learning to use digital technologies fosters a sense of accomplishment, while easy access to news, local events, and resources ensures seniors remain informed and engaged in their communities. These tools also bridge generational gaps, as social apps enable elderly to stay in touch with younger family members and reducing the digital divide.

Lifelong learning and fulfillment are additional benefits of ICT integration. Online platforms provide access to courses, webinars, and resources that allow elderly to explore new hobbies or develop new skills. By leveraging ICT and innovative devices, elderly can enjoy tools, that can help reduce loneliness, foster a sense of purpose and connection, and ultimately enhance overall well-being.

Another recommendation for improvement in the quality of care is related to the re-evaluation of parameters used to measure services for the elderly. For example, length of hospitalization is a measure that is currently widely used in global health systems for calculating the cost of funding received by a medical institution. That being said, this method directly impairs the quality of care afforded to elderly patients with dementia. The initial days of hospitalization, especially in emergency medicine, are the most expensive in the system. However, premature discharge of a patient with dementia increases the recurrence rate due to the same problem. That is to say, a standard remuneration method, whereby a medical institution is rewarded for short-term rather than long-term hospitalizations and even receives long-term penalties, is not beneficial for an institution that provides emergency medical services to elderly patients. Additionally, rehabilitation units created in hospitals to shorten hospitalization for other chronic patients are also unsuitable for dementia patients.

Elderly people with dementia cannot take advantage of the rehabilitation offered to them in the proposed framework, due to cognitive decline. To solve this problem, the authors of the article recommend not only changing the financial remuneration for hospitals that provide emergency services to patients with dementia, but also adopting a rehabilitative framework that takes into account the needs of dementia patients who are different from those of elderly people of the same age without dementia (Gill, et al., 2017).

One of the other notable recommendations that emerges from the literature is a change in the field of pain management that could significantly change the situation for the better. In light of the effects of pain on disease progression, treatment of this issue becomes important and urgent in terms of managing the disease. Today, the lack of effective pain assessment tools in conscious dementia patients causes nurses to use their personal feelings and play a "guessing game" when it comes to an elderly dementia patient in pain. The development of tools in patients with dementia to identify the intensity and location of the pain, and the implementation of this tool in the healthcare system is a primary duty of caregivers on the path to achieving quality care (Lichtner, et al., 2016, p. 2).

Given the high and consistent increase in the proportion of dementia patients, the World Health Organization has proposed that governments place dementia high on a priority scale of the public healthcare system. High-quality care begins with mapping out the needs of both caregivers and patients (Hansen, et al., 2017). Promoting quality of care for dementia patients should begin by formulating a definition of "good care" for dementia patients. To provide a professional solution to a variety of problems associated with dementia, it is necessary to build a multi-professional and integrative care team that can build one treatment that will cover all needs of the patient and his or her family under one roof. Today, different caregivers are isolated in their specialty of practice. A multitude of institutions providing services, and a great deal of overlap between service types and unmet needs – lead to the conclusion that only multi-professional teamwork will help overcome the huge gap that exists between patients' needs and the provision of adequate, full and professional solutions. The requirement for a multi-professional caregiver team is universal and similar across countries, however, there is no single solution to the issue. A team from one country will not be similar to one from another. A smart assembly of a team should be based on values and norms that characterize the population. Therefore, each country must choose a suitable composition of attending staff and proper goals in treating dementia patients. That is to say, the cultural background of a dementia patient and his or her caregivers is crucial in terms of mapping and achieving goals in treating dementia patients. Furthermore, developing and promoting quality care for dementia patients is a process and can therefore take years. The right process will start from a thorough gathering of data and later from evidence-based practice (Moore, et al., 2017). For example, the medical field is still not providing satisfactory answers regarding mechanical ventilation in dementia patients, urgent surgical interventions in these patients, postoperative hip rehabilitation, and other medical operations (Gill, et al., 2017). The lack of research data on prudent professional practice is not surprising at all. It is well known that the quality of care depends on the alertness and high awareness of caregivers with in-depth knowledge regarding patients' illnesses and the availability of sufficient resources, as well as freedom in decision-making regarding treatment, according to the dementia patient's personality. However, today, when the treatment of patients with dementia is performed by unskilled and unknowledgeable random caregivers, establishing trust-based communication and controlling the therapeutic situation is impossible. Thus, the treatment that patients receive is not of high quality, and sometimes even harmful and damaging (Hansen, et al., 2017). The situation is similar to the feeding of elderly people in general and dementia patients in particular. Researchers from Switzerland argue that treating elderly people with dementia should begin by formulating identical and universal guidelines for all institutions treating dementia patients on non-contentious issues, such as dysphagia. Dysphagia and feeding problems are conditions characterizing most patients with dementia, so clear guidelines on these issues will advance the quality of general care for these patients (Austbo Holteng, et al., 2017). That being said, feeding dementia patients, especially those in advanced stages of the disease, is only one component of the therapeutic complex, and therefore not sufficient. It is important to build a high-quality system that meets the diverse needs of dementia patients, treats both patients and caregivers, and develops according to system experience (de Boer, et al., 2017). Additionally, a professional system that builds on collaboration among a variety of caregivers is essential, but is not built in a day and requires investment in health care resources (Arcand, 2015). Other researchers also see the importance of building a therapeutic system that emphasizes both the patient's and the caregiver's needs. Thus, in light of research findings in Germany, showing a high rate of burnout among dementia patient caregivers, it is advisable to build a support system for these caregivers, especially when it comes to an informal setting. It is also important to build a professional system that includes a multi-professional team for treating patients with dementia which can reduce the hours of care provided by an informal caregiver. Investing in caregivers will result in more professional care for elderly dementia patients. The formal therapeutic framework built in the future should map out all needs and challenges associated with treatment, including the increased mental and physical burden and high levels of burnout associated with treating elderly people with dementia (Karg, et al., 2018). The mental burden over many years leads to the development of mental illness, such as clinical depression, which in some cases will require medication or even hospitalization. It should be emphasized that mental overload, multitasking, shortage of caregivers, and multiple patients are all common problems. Flawed communication harms both parties, so finding a solution will benefit both patients and caregivers (Goeman, et al., 2016).

One of the key recommendations in this literature is investment in caregiver training. Mental resilience and the ability to demonstrate empathy in daily care for patients with cognitive decline is an important and necessary aspect of holistic care, although not the only one. A great deal of knowledge is required as well as the training of caregivers directed at treating dementia patients. According to many caregivers, the lack of knowledge and skill in the training of caregivers is a very significant barrier to providing appropriate care for elderly patients with dementia. Therefore, professional caregivers must continually expand their knowledge and professional skills. Structured and consistent formal training for all caregivers of elderly patients with dementia enables the provision of quality and safe care and contributes to informed decision-making by both staff and family members, regarding the necessity of performing various medical activities in a patient with dementia. For example, today about

74.6% of doctors mistakenly believe that the use of a feeding tube improves the nutritional status of an elderly person with dementia. Thus, decisions made by caregivers, whose knowledge is not only inaccurate, but incorrect, will result in mistakes and poor therapeutic outcomes for patients who are unable to make decisions for themselves (Hwang, et al., 2014; Goeman, et al., 2016). That being said, up-to-date knowledge, and good clinical skills in identifying medical signs and symptoms constitute a good, but not sufficient, therapeutic basis. Achieving quality of care relies on caregivers' interest in a patient's social and cultural background and his or her family members. The caregiver's sensitivity to the elderly's cultural background will not only help in understanding dementia in a patient's context but also create strong communication infrastructures for therapeutic interaction between a dementia patient and his or her family. Thus, caregivers create a comfortable atmosphere that contributes to the mental well-being of both patients and caregivers (Malak, et al., 2016). Researchers from Germany also support this claim. They believe that developing appropriate clinical skills for treating patients with dementia, relevant knowledge, and training, not only help prevent unnecessary hospitalizations for dementia patients, but also reduces the proportion of patients who die as a result of this hospitalization (Pohontsch, et al., 2017). Other researchers also believe that extensive medical knowledge and well-developed clinical competence are valuable resources for the caregiver, but that fulfilling the psychological and spiritual needs of a dementia patient is also an integral part of care. Today, contrary to the desired situation, conventional treatment only meets the medical and physical aspects of the treatment of a dementia patient. Preferred medical care begins with appreciation and respect, love, confidence, and a sense of belonging that form the general basis for communication in the therapeutic arena. So, it is expected that therapeutic frameworks with a humane attitude toward the caregiver team will inevitably provide humane and respectful treatment for dementia patients (Hansen, et al., 2017). Researchers from Canada argue that there is a basic and significant need for cultural change among caregivers and policymakers as to the treatment of dementia patients and their family members, which in the future will bring about social change towards the concept of dementia in society. The required change will begin with the development of special strategies that place the dementia patient in a therapeutic center, as opposed to the situation today. Developing a positive attitude towards patients with dementia will enable caregivers who can provide full compassionate and empathy-based care for the elderly, alongside the daily needed care. Elderly people with dementia need professional but sensitive treatment, like all patients with other illnesses, regardless of their age. Therefore, it is extremely important to provide practitioners with professional tools to create a supportive, sensitive and professional care environment for dementia patients (Martin, et al., 2016; Asamani, et al., 2017).

Thus, quality treatment for dementia patients appears to begin with support for caregivers. Creating a professional social network that facilitates the mental and physical well-being of their work will positively influence the interaction with dementia patients and their family members. Otherwise, demands placed on caregivers lead to rapid burnout that will lead to a decrease in work efficiency and increased mental stress. Stress reduction in caregiver work is possible through proper training, providing information, and acquiring psychosocial tools for coping with difficulties in treating dementia patients. This can be done by developing smart technologies for caregivers. Such an approach will enable a diverse, professional and individual response to both caregiver and patient needs (Malak, et al., 2016; Goeman, et al., 2016).

The nurses who participated in the current study underscore the essential link between enhancing caregiver working conditions and improving the quality of care for the elderly. They emphasize the vital need for a conducive physical and environmental treatment setting that includes spacious, well-equipped rooms tailored for nursing patients, adequate supplies of essential equipment like cushions and individual armchairs per patient. The availability of comfortable and innovative equipment accessible to caregivers significantly enhances their daily work experience. Presently, the reality reflects a shortage of basic resources, often with outdated or inadequate facilities.

Furthermore, discussions on enhancing the physical treatment environment should encompass considerations for upgrading facilities such as changing rooms, toilets, and the kitchen, all integral components of the care team's workspace. Current challenges include overcrowding and discomfort due to insufficient space and substandard equipment quality. Additionally, designated staff rooms meant for brief breaks and meals during shifts are often visitor-accessible and fail to provide adequate rest opportunities.

Another recommendation from nurses in this study is to maintain supportive, respectful and eye-level communication while evaluating the work of the nurses.

Many negative factors entailed by the performance of the nurse's work, such as constant tension, work in shifts, the appearance of chronic illness throughout the working years, and negative practices (smoking, alcohol consumption, abuse of painkillers), emphasize the need for the health monitoring of health workers, especially those (for example, nurses) who are exposed to high demands in their role. Based on data from research on nurses in Estonia, healthier nurses will provide better care (Freiman, et al., 2016). The work of Chen, et al., (2020) presents similar data: nurses who have a healthy lifestyle (balanced diet, adequate hours of sleep, etc.) provide safer care (Cheng, et al., 2020). There is no doubt that monitoring the caregiver's health situation is important for the organization and the caregiver. However, as presented in work among nurses in Poland, chronic illness does not directly influence the nurses' satisfaction with their work or their decision to leave the organization. The nurses are influenced first of all by the atmosphere in the organization and among the staff with which they work. Thus, it is recommended to list people from the organization/staff who will take care of events aimed at forming a team in the department and the organization (Kowalczuk & Krajewska-Kulak, 2015). Furthermore, research carried out in Holland emphasizes that alongside special demands on the nurses that cause great emotional tension, they have unique resources that characterize only them from a wide variety of caregivers. These resources come from different and diverse sources, such as personality, the nature of the atmosphere in the organization and the staff, the quality of the leadership, social support created in the workplace, and so on (Van der Heijden, et al., 2019).

The reduction of the load in the number of tasks, distribution of the responsibility among many more staff members, respect, and a sense of appreciation of the superiors for the caregivers, and creation of opportunities for further development in the workplace – these are essential conditions for the improvement of the situation in the health system. However, caregivers whose work is characterized by many hours, work in shifts and many psychological difficulties caused by the care of people are supposed to receive a salary commensurate for their work. However, in the daily reality, the salary for the caregiver is low and is not commensurate with the caregivers' challenges in their work (Kowalczuk, et al., 2019). In addition, when talking about nurses who work in hospitals, their situation is worse. Thus, it is important to begin with the advancement of appropriate workplace conditions, enough time to recover after shifts, reduction of the factors of tension, and construction of social support

(Jalilian, et al., 2019). According to researchers from Israel, first, it is necessary to increase the general percentage of nurses in the health system in Western countries in general and in Israel in particular. They maintain that it is not possible to deal otherwise with the burden placed on the shoulders of nurses who are found 24 hours at the patient's bedside. For this purpose, it is necessary to build tailored strategies that are suited to the recruitment of new personnel and the care of nurses already in the system (Nirel, et al., 2015). According to Van der Heijden et al. (2019), appropriate salary and social support are important factors but not exclusive in changing for the better the caregivers' situations. They maintain that autonomy in action, a feeling of control, participation in decision-making, high professional status, and respectful leadership are factors that compensate the nurses for the demanding requirements of their role. Therefore, to retain nurses in the organization, it is important to take these factors into account. In addition, correct recruitment and constant development of the caregivers who have already been recruited will help lessen the rate of dropout among caregivers in general and nurses in particular (Van der Heijden, et al., 2019). Asamani et al. (2017) see the correct recruitment of caregivers as the pillar of professional care of high quality. In their opinion, it is necessary to recruit caregivers with positive attitudes toward the patients. In parallel with proper recruitment, it is necessary to advance positive attitudes in the existing health system and even to terminate caregivers whose attitudes towards certain groups of patients are negative to the extreme (Asamani, et al., 2017).

However, not all researchers agree with the argument that investing in caregivers alone will provide quality care for elderly patients with dementia. According to researchers from Switzerland, it is first necessary to allow patients with dementia to stay at home while providing the necessary support and services. This is possible after mapping the individual needs of each patient and his or her family. They believe that treatment of an elderly person with dementia at home is more holistic than treatment at an institution, where the emphasis in treatment is medical-therapeutic with complete neglect of the psychological-spiritual aspect of the patient. Advancement of care, when placed at the center, in a genuine and not merely declarative way, requires time which institutional caregivers lack, leading to the reality that attaining quality care at an adequate level is impossible in an institution. Additionally, general and standard care for all dementia patients is perceived by the system as a time and expense saver for public medicine. True, such a view of treating dementia patients by saving time does not allow for individualized and flexible treatment that takes into account the psychological needs of patients. But this is how it achieves care for as many patients as possible even if it fails to guarantee high-quality care (Hansen, et al., 2017). This approach is not widely accepted by scholars. Many believe that a public system can provide proper and appropriate treatment for dementia patients. Thus, the building of an elderly care system should incorporate the three approaches to care: managing care, integrative care and patient-oriented care, allowing caregivers to develop effective tools for therapeutic intervention in elderly patients with dementia. Creating individualized care for dementia patients helps caregivers develop self-efficacy in providing quality care while maintaining their mental health as well as that of their patients (Malak, et al., 2016; Goeman, et al., 2016).

Today, modern Western society has created a multiplicity of diversity of social organizations. The field of health and medicine constitutes one of the prominent examples of this. Medical organizations have always been established to protect and support the caregivers in their professional roles, to allow them to provide the best care, alongside the maximum profit and the preservation of rights within the framework of the role. Conversely, organizations of patients were founded for the same goals. Their role is to protect patients, to see to the patients' well-being, and to promote the best care for them. In other words, two types of organizations, physicians and patients, act to achieve one goal: to improve the quality of care provided to the patients. Therefore, the time has come for true and close cooperation between organizations for caregivers and organizations for patients (Panagopoulou, et al., 2015).

Developing a new philosophy where we consciously adhere to the values of respect and autonomy for seniors living in an institution, regardless of whether they are dementia patients, will create an atmosphere that inhibits the formation of stigma. On a practical level, private (not shared) bedrooms, and a personal (flexible) schedule that allows eating, sleeping and recreation according to the elderly people's personal choice should be arranged (Dobbs, et al., 2008). In addition to this, a real change in care for dementia patients will come from the political and legal system. Creating laws and implementing them in society will create a new social reality and bring about the necessary change in the field (Werner & Doron, 2017; Srinivas, et al., 2018).

Before it is too late, first it is necessary to begin with the education of the elderly themselves. It is necessary to build a broad understanding of old age that will include self-discovery and self-acceptance while respecting the person's inner voice and social alternatives as well as the elderly person's images and fears. Such an education for old age is a very complex process that includes all social levels and is based on the value of giving respect to life of any kind, which is currently lacking in modern society in general. The acceptance of an elderly person in society with respect and without conditions is significant for society's existence in the future (Hansen, et al., 2017).

The time has come to stop seeing the phenomenon of aging only through "…the prism of the question 'how much does it cost and who will pay for it' (Rosochacka-Gmitrzak, 2016, p. 100).

A society that expresses the equality of rights for all the social groups composing it is supposed to create a conceptual change regarding aging and old age, not only among young people but also first among the elderly themselves. The elderly are not supposed to search for sources of self-respect among young people or workers. They are supposed to create and strengthen the social status of old age by themselves, which will achieve appreciation and will be identified in society with quality and success and not with weakness and fear. Only in this way is it possible to entrench respect for the elderly over many years among young people (Rosochacka-Gmitrzak, 2016).

In conclusion, researchers are advocating for improving care quality by reassessing service evaluation parameters, like the length of hospital stays. Short-term hospitalization often leads to premature discharge and higher recurrence rates, indicating that a shift towards long-term, comprehensive care is needed. Also, pain management is another critical area. Effective pain management is a cornerstone of dementia patient care, but it is lacking.

High-quality care requires a multi-professional, integrative approach tailored to the cultural context of patients and caregivers. This involves extensive training for caregivers, focusing on both medical knowledge and empathy, to handle the unique challenges of dementia care.

Additionally, caregiver support is crucial to prevent burnout and ensure sustained quality care. This includes improving working conditions, providing adequate resources, and fostering a supportive environment. Proper training and recruitment, along with fair remuneration and professional development opportunities, are essential for retaining skilled caregivers.

Finally, societal attitudes towards aging need to shift. Promoting respect and autonomy for the elderly, improving caregiver-patient relationships, and fostering societal acceptance of aging are fundamental for enhancing dementia care. Education on aging and proactive policy changes are necessary to create a supportive environment for dementia patients and their caregivers.

9. References:

A general surgeon. (2018). As we continue to drift into a Totalitarian Medical System: A View of a Country Boy. *Scandinavian Journal of Surgery, 107*(1), 3-5.

Aaltonen, M., Raitanen, J., Forma, L., Pulkki, J., Rissanen, P., & Jylha, M. (2014). Burdensome transition at end of life among long-term care residents with dementia. *JAMDA, 15*, 643-648.

Abdel-Hadi, A. (2012). Culture, quality of life' globalization and beyond. *Procedia-Social and Behavioral Sciences, 50*, 11-19.

Ajzen, I., & Fishbein, M. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research.* Reading, MA: Addison-Wesley.

Allport, G. W. (1935). *Attitudes.* (C. Murchison, Ed.) Worcester: Clark University Press.

Alon, S., & Berg-Warman, A. (2014). Treatment and Prevention of Elder Abuse and Neglect: Where Knowledge and Practice Meet - A Model for Intervention to Prevent and Treat Elder Abuse in Israel. *Journal of Elder Abuse & Neglect, 26*, 150-171.

American Geriatrics Society Ethnogeriatrics Committee. (2016). Achieving high-quality multicultural geriatric care. *Journal of American Geriatric Society, 64,* 255-260.

Angelman, M., & Ben-Haim, E. (February 2023). Challenges and goals in providing service to the elderly - lessons from investigating complaints. (O. o. Ombudsman, Ed.) 1-140.

Antonovsky, A. (1993). The structure and properties of the sense of coherence scale. *Social science & medicine, 36*(6), 725-733.

Arcand, M. (2015). End-of-life issues in advanced dementia. Part 1: goals of care, decision-making process, and family education. *Canadian Family Physician, 61*, 330-334.

Arcand, M. (2015). End-of-life issues in advanced dementia. Part 2: management of poor nutritional intake, dehydration, and pneumonia. *Canadian Family Physician, 61*, 337-341.

Asamani, L., Agyemang, B. C., Afful, J., & Asumeng, M. (2017). Work attitude of Ghanaian nurses for quality health care service delivery: Application of individual and Organizational Centered (IOC) interventions. *International Journal of Research Studies in Management, 7*(1), 37-46.

Atherton, N., Bridle, C., Brown, D., Collins, H., Dosanjh, S., Griffiths, F., . . . Lamb, S. E. (2016). Dementia and physical activity (DAPA) - an exercise intervention to improve cognition in people with mild to moderate dementia: study protocol for a randomized controlled trial. *BioMed Central, 17*(165), 1-12.

Austbo Holteng, L.B., Froiland, C.T., Corbett, A., & Testad, I. (2017). Care staff perspective on use of texture modified food in care home residents with dysphagia and dementia. *Annals of Palliative Medicine*, *6*(4), 310-318.

Ayalon, L. (2014). Reports of Elder Neglect by Older Adults, Their Family Caregivers, and Their Home Care Workers: A Test of Measurement Invariance. *Journal of Gerontology, Series B: Psychological Sciences and Social Sciences, 70*(3), 432-442.

Bai, X. (2014). Images of aging in society: A Literature review. *Population Aging, 7,* 231-253.

Bakker, A. B., Schaufeli, W. B., Sixma, H. J., Bosveld, W., & Van Dierendonck, D. (2000). Patient demands, lack of reciprocity, and burnout: A five-year longitudinal study among general practitioners. *Journal of Organizational Behavior*, 425-441.

Bauman, Z. (1998). *Globalization. The Human Consequences.* New York: Columbia University Press.

Bauman, Z. (2004). *Wasted Lives: Modernity And Its Outcasts.* Cambridge: Polity Press.

Bauman, Z. (2007). *Liquid Times: Living in an Age of Uncertainty.* Cambridge: Polity Press.

Bauman, Z. (2008). *Liquid Modernity.* Cambridge: Polity Press.

Bauman, Z. (2008). *The Art of Life.* Cambridge: Policy Press.

Beck, U. (1992). *Risk society. Towards a New Modernity.* London: Sage Publication Ltd.

Ben Dov, D. (2014, June 10). *Euthanasia in Israel - Murder or Mercy?* Retrieved from https://www.clalit.co.il/he/your_health/elders/support/Pages/Euthanasia.aspx

Ben Mitchell, C. (2015). Why Doctors Must Not Be Complicit in Killing Their Patients. *Ethics & Medicine, 31*(2), 69-70.

Ben Natan, M., & Tabak, N. (2013). Combating the Maltreatment of Older Persons by Staff in Long-Term Care Nursing Homes: Legal Aspects. *Medicine and Law, 32,* 53-64.

Bentur, N., & Sternberg, S. A. (2019). Dementia care in Israel: Top-down and Bottom-up processes. *Israel Journal of Health Policy Research, 8*(22), 1-6.

Bertelli, M; Bianco, A; Rossi, M; Scuticchio, D; Brown, I. (2011). Relationship between individual quality of life and family quality of life for people with intellectual disability living in Italy. *Journal of Intellectual Disability Research, 55 (12),* 1136- 1150.

Bollig, G., Gjengedal, E., & Rosland, J. H. (2016). They Know!-Do they? A qualitative study of residents and relatives views on advance care planning, end-of-life care, and decision-making in nursing homes. *Palliative Medicine, 30*(5), 456-470.

Botseas, D. S., & Drosou, A. L. (2014). Euthanasia: Act of Charity, or Murder. *Hellenic Journal of Surgery, 86*(1), 1-4.

Boughtwood, D., Shanley, C., Adams, J., Santalucia, Y., Kyriazopoulos, H., Pond, D., & Rowland, J. (2011). Culturally and linguistically diverse (CALD) Families dealing with dementia: an examination of the experiences and perception of multicultural community link workers. *Journal of Cross-Cultural Gerontology, 26*, 365-377.

Brooker, D. (2004). What is person-centered care in dementia? *Reviews in Clinical Gerontology*(13), 215-222.

Broyard, A. (1993). The Patient Examines the Doctor. In A. Broyard (Ed.), *Intoxicated by my Illness. And Other Writings on Life and Death* (pp. 33-58). New York: Fawcett Columbine.

Bury, M., Rozenek, H., Kaminski, A., Czerwinski, J., Wojtowicz, S., Banasiewicz, J., & Owczarek, K. (2019). Professional burnout and its correlates in Polish donor transplant coordinators. *Cell Tissue Bank, 20*, 535-544.

Cadoret, C. A., & Garcia, R. L. (2014). Health disparities and the multicultural imperative. *The journal of evidence-based dental practice, 14*(1), 160-171.

Campos, B. (2015). What is the role of culture in the association of relationships with health? *Social and Personality Psychology Compass*(9/11), 661-677.

Carrard, V., Schmid Mast, M., & Cousin, G. (2017). Beyond "One Size Fits All": Physician Nonverbal Adaptability to Patients' Need for Paternalism and Its Positive Consultation Outcomes. *Health Communication, 31*(11), 1327-1333.

Castells, M. (2010). *The Rise of the Network Society* (Vol. 1). Oxford: Blackwell Publishing Ltd.

Central Bureau of Statitics (2022). *Israel in Figures Selected Data From the Statistical Abstract of Israel.* Jerusalem: Central Bureau of statistics Reports .

Central Bureau of Statistics. (2024, March). Retrieved from Central Bureau of Statistics: https://www.cbs.gov.il/en/Pages/default.aspx

Cheng, H., Yang, H., Ding, Y., & Wang, B. (2020). Nurses' mental health and patient safety: An extension of the Job Demands-Resources model. *Journal of Nursing Management*, 1-12.

Cheong, C. Y., Tan, J. A., Foong, Y. L., Koh, H. M., Chen, D. Z., Chen Tan, J. J., . . . Yap, P. (2016). Creative Music Therapy in an Acute Care Setting for Older

Patients with Delirium and Dementia. *Dementia and Geriatric Cognitive Disorder Extra, 6*, 268-275.

Connell, J., O'Cathain, A., & Brazier, J. (2014). Measuring quality of life in mental health: Are we asking the right questions? *Social Science & Medicine, 120*, 12 - 20.

Converso, D., Sottimano, I., Viotti, S., & Guidetti, G. (2020). I'll be a caregiver-employee: Aging of the Workforce and family-to-work Conflicts. *Frontiers in Psychology*, 1-14.

Cooley, C. H. (1902). *Human Nature and the Social Order*. New York: Charles Scribner's Sons.

de Beauvoir, S. (1996). *The coming of Age*. (P. O'brain, Trans.) W. W. Norton & Company.

de Boer, B., Hamers, J., Zwakhalen, S., Tan, F., & Verbeek, H. (2017). Quality of care and quality of life of people with dementia living at green care farms: across-sectional study. *BMC Geriatrics, 17*(155), 1-10.

de Mooij, L. D., Kikkert, M., Lommerse, N. M., Peen, J., Meijwaard, S. C., Theunissen, J., . . . Beekman, A. T. (2015). Victimisation in adults with severe mental illness: prevalence and risk factors. *The British Journal of Psychiatry, 207*, 515-522.

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The Job Demands-Resources Model of Burnout. *Journal of Applied Psychology, 86*(3), 499-512.

Dening, K. H., Jones, L., & Sampson, E. (2012). Preferences for end-of-life care: A nominal group study of people with dementia and their family carers. *Palliative Medicine, 27*(5), 409-417.

Dierickx, S., Deliens, L., Cohen, J., & Chambaere, K. (2016). Euthanasia in Belgium: trends in reported cases between 2003 and 2013. *CMAJ, 188*(16), E407-E414.

Dobbs, D., Eskert, K., Rubinstein, B., Keimig, L., Clark, L., Frankowski, A. C., & Zimmerman, S. (2008). An Ethnographic Study of Stigma and Ageism in Residential Care or Assisted Living. *Gerontologist, 48*(4), 517-26.

Dong, X. Q., & Simon, M. (2015). Association Between Elder Abuse and Metabolic Syndromes: Findings from the Chicago Health and Aging Project. *Gerontology, 61*(5), 389-398.

Dong, X. Q., Chen, R., & Simon, M. A. (2014). Elder Abuse and Dementia: A Review of The Research and Health Policy. *Health Affairs. At the Intersection of Health, Health care and Policy, 33*(4), 642-649.

Dong, X., Milholland, B., & Vijg, J. (2016). Evidence for a limit to human lifespan. *Nature*(538), 257 - 265.

Dousdampanis, P., Trigka, K., & Fourtounas, C. (2012). Diagnosis and management of chronic kidney disease in the elderly: a field of ongoing debate. *Aging and Disease, 3*(5), 360-370.

Dworkin, G. (1972). Paternalism. In R. A. Wasserstrom (Ed.), *Mortality and the Law* (pp. 181-188). Belmont: Wadsworth Publishing Company.

Eagly, A. H., & Chaiken, S. (1993). *The psychology of attitudes.* Harcourt Brace Jovanovich College Publishers.

Ekra, E. M., & Dale, B. (2020). Systematic Use of Song and Music in Dementia Care: Health Care Providers' Experiences. *Journal of Multidisciplinary Healthcare, 13,* 143-151.

Elyzra, R., & Blumenthal, A. (2017, July 05). *Admission to senior home on hold due to suspicion of abuse that led to death*. Retrieved from Y NET, Yediot Acharonot: https://www.ynet.co.il/articles/0,7340,L-4985037,00.html (In Hebrew)

Erel, M., Marcus, E. L., & Dekeyser-Ganz, F. (2017). Barriers to palliative care for advanced dementia: a scoping review. *Annals of Palliative Medicine, 6*(4), 365-379.

Erikson, E., & Joan, M. (1997). *The life cycle completed: extended version.* New York: W.W. Norton.

Eurostat. (2024, March). Retrieved from https://ec.europa.eu/eurostat/data/database

Farley, S. D., & Stasson, M. F. (2003). Relative Influences of Affect and Cognition on Behavior: Are Feeling or Beliefs /more Related to Blood Donation Intentions? *Experimental Psychology, 50*(1), 55-62.

Farre, M., Haro, J., Kostov, B., Alvira, C., Risco, E., Miguel, S., . . . Zabalegui, A. (2015). Direct and indirect costs and resource use in dementia care: A cross-sectional study in patients living at home. *International Journal of Nursing Studies, 55,* 39-49.

Fassio, O., Rollero, C., & De Piccoli, N. (2013). Health, quality of life and population density: A preliminary study on "contextualized" quality of life. *Social indicators research, 110,* 479 - 488.

Fernandez - Castro, J., Martinez - Zaragoza, F., Rovira, T., Edo, S., Solanes - Puchol, A., Martin - del - Rio, B., . . . Doval, E. (2017). How does emotional exhaustion influence work stress? Relationships between stressor appraisal, hedonic tone, and fatigue in nurses' daily tasks: A longitudinal cohort study. *International Journal of Nursing Studies, 75,* 43-50.

Fernandez-Ballesteros, R., Sanchez-Izquierdo, M., Olmos, R., Huici, C., Ribera Casado, J. M., & Jentoft, A. C. (2019). Paternalism vs. Autonomy: Are They Alternative Types of Formal Care? *Frontiers in Psychology, 10*, 1-4.

Ferriss, A. L. (2004). The quality of life concept in sociology. *The American Sociologist*, 31-51.

Fleming, J., Calloway, R., Perrels, A., Farquhar, M., Barclay, S., & Brayne, C. (2017). Dying comfortably in very old age with or without dementia in different care settings - a representative "older old" population study. *BMC Geriatrics, 17*(222), 1-17.

Formosa, M., & Mackowicz, J. (2019). Elder Abuse: International and Polish Perspectives. *International Journal on Ageing in Developing Countries, 4*(2), 145-155.

Forte, R., Boreham, C. A., De Vito, G., & Pesce, C. (2015). Health and quality of life perception in older adults: The joint role of cognitive efficiency and functional mobility. *Environmental Research and Public Health, 12*, 11328 - 11344.

Foucault, M. (1980). *Power/ Knowledge. Selected Interviews & Other Writings 1972 - 1977.* (L. M. Colin Gordon, Trans.) New York: Colin Gordon.

Foucault, M. (1994). *The Birth of the Clinic. An Archaeology of Medical Perception.* (A. Smith, Trans.) New York: Pantheon Books.

Frances Wand, A. P., Peisah, C., Draper, B., Jones, C., & Brodaty, H. (2016). Case Report. Rational Suicide, Euthanasia, and the Very Old: Two Case Reports. *Hindawi Publishing Corporation Case reports in Psychiatry*, 1-5.

Frankl, V. (2006). *Man's search for meaning. (with a new foreword by Harold S. Kushner).* (I. Lasch, Trans.) Boston, Massachusetts, United States of America: Beacon Press.

Freiman, T., Paasuke, M., & Merisalu, E. (2016). Work-Related Psychosocial Factors and Mental Health Problems Associated with Musculoskeletal Pain in Nurses: A Cross-Sectional Study. *Pain Research and Management*, 1-7.

Gal, A. (2013, October 27). *Bill: A patient can commit suicide with a prescription from the doctor.* Retrieved from Y NET Yediot Acharonot: https://www.ynet.co.il/articles/0,7340,L-4446222,00.html (In Hebrew)

Gal, A. (2016, July 13). *The Knesset rejected - there will be no euthanasia in Israel*. Retrieved from Y NET Yediot Acharonot: https://www.ynet.co.il/articles/0,7340,L-4827930,00.html (In Hebrew)

Gavrilov, L. A., Krut'ko, V. N., & Gavrilova, N. S. (2017). The Future of Human Longevity. *Gerontology, 63*(6), 524 - 526.

Gerlich, M. G., Klindtworth, K., Oster, P., Pfisterer, M., Hager, K., & Schneider, N. (2012). "Who is going to explain it to me so that I understand?" Health care needs and experiences of older patients with advanced heart failure. *European Journal of Aging, 9*, 297-303.

Germain, M. J. (2015). Should dialysis be offered to all elderly patients? *Blood Purification, 39*, 55-57.

Geyer, S. (1997). Some conceptual considerations on the sense of coherence. *Pergamon, 44*(12), 1771-1779.

Giddens, A. (1991). *Modernity and Self-Identity. Self and Society in the Late Modern Age.* Stanford, California: Stanford University Press.

Giddens, A. (2000). *Runaway World: How Globalization is Reshaping our Lives.* London: Routledge.

Gill, N., Hammond, S., Cross, J., Smith, T., & Lambert, N. (2017). Optimizing care for patients with cognitive impairment and dementia following hip fracture. *Zeitschrift fur Gerontologie und Geriatrie,* S39-S43.

Ginis, K., Heisz, J., Spence, J., Clark, I., Antflick, J., Ardern, C., . . . Rotondi, M. (2017). Formulation of evidence-based messages to promote the use of physical activity to prevent and manage Alzheimer's disease. *BioMed Central Public Health, 17*(209), 1-17.

Goddu, A. P., O'Conor, K., Lanzkron, S., Saheed, M. O., Saha, S., Peek, M. E., . . . Beach, C. (2018). Do Words Matter? Stigmatizing Language and the Transmission of Bas in the Medical Record. *The Journal of General Internal Medicine, 33*(5), 685-91.

Godwin, M., Pike, A., McCrate, F., Parsons, K., Parsons, W., Pitcher, H., . . . Sclater, A. (2015). The healthy aged. *Canadian Family Physician*, e142 - e147.

Goeman, D., Renehan, E., & Koch, S. (2016). What is the effectiveness of the support worker role for people with dementia and their carers? A systematic review. *BMC Health Services Research, 16*(285), 1-36.

Goffman, E. (1959). *The Presentation of Self in Everyday Life.* New York: Anchor Books. A Division of Random House, Inc.

Goffman, E. (1961). *Asylums. Essays on the social situation of mental patients and other inmates.* New York: Anchor Books. Doubleday & Company, Inc.

Goffman, E. (1986). *Stigma: notes on the management of spoiled identity.* New York, London, Toronto: Simon & Schuster Inc.

Goldberg, L. S., & Altman, K. W. (2014). The role of gastrostomy tube placement in advanced dementia with dysphagia: a critical review. *Clinical Interventions in Aging, 9*, 1733-1739.

Goren, A., Montgomery, W., Kahle-Wrobleski, K., Nakamura, T., & Ueda, K. (2016). Impact of caring for person with Alzheimer's disease or dementia on caregivers' health outcomes: Findings from a community based survey in Japan. *BMC Geriatrics*(16), 1-12.

Grasset, L., Joly, P., Jacqmin-Gadda, H., Letenneur, L., Wittwer, J., Amieva, H., . . . Dartigues, J. (2017). Real benefit of a protective factor against dementia: Importance of controlling for death. Example of sport practice. *PLOS ONE, 12*(4), 1-9.

Grossman, G. (2011, 08 08). *Not only Adi Talmor: Israelis who want to die with dignity*. Retrieved from Walla: https://news.walla.co.il/item/1848622 (In Hebrew)

Guan, J., Li, H., Sun, H., Wang, T., & Wu, W. (2015). The impact of a discrepancy between actual and preferred living arrangements on life satisfaction among the elderly in China. *Clinics, 70 (9)*, 623 - 627.

Gutman, G., & Yon, Y. (2014). Elder abuse and neglect in disasters: Types, prevalence and research gaps. *International Journal of Disaster Risk Reduction, 10,* 38-47.

Hadziabdic, E., Lundin, C., & Hjelm, K. (2015). Boundaries and conditions of interpretation in multilingual and multicultural elderly healthcare. *BioMedCentral-Health Services Research, 15*(458), 1-13.

Han, K., Lee, Y., Gu, J., Oh , H., Han, J., & Kim, K. (2015). Psychosocial factors for influencing healthy aging in adults in Korea. *Health and Quality of Life Outcomes*, *13, 31*, 1 - 10.

Hansen, A., Hauge, S., & Bergland, A. (2017). Meeting psychosocial needs for persons with dementia in-home care services - a qualitatite study of different perceptions and practices among health care providers. *BMG Geriatrics, 17*(211), 1-10.

Harries, P., Yang, H., Davies, M., Gilhooly, M., Gilhooly, K., & Thompson, C. (2014). Identifying and enhancing risk thresholds in the detection of elder financial abuse: a signal detection analysis of professionals' decision making. *BMC Medical Education, 14*(1044), 1-12.

Hazzan, A., Shannon, H., Ploeg, J., Raina, P., Gitlin, L., & Oremus, M. (2016). The association between caregiver well-being and care provided to persons with Alzheimer's disease and related disorders. *BioMed Central Research Notes, 9,* 1-8.

Heidarnia, M. A., & Heidarnia, A. (2016). Sick Role and a Critical Evaluation of its Application to Our Understanding of the Relationship between Physician and Patients. *Novelty in Biomedicine*(3), 126-134.

Hofstede, G. H. (2001). *Culture's Consequences: Comparing values, behaviors, institutions, and organizations across nations* (2 ed.). California: Sage Publication, Inc.

Holmes, S. M. (2012). The clinical gaze in the practice of migrant health: Mexican migrants in the United States. *Social Science & Medicine, 74,* 873-881.

Hoover, R. M., & Polson, M. (2014). Detecting Elder Abuse and Neglect: Assessment and Intervention. *American Family Physician, 89*(6), 453-460.

Houttekier, D., Vandervoort, A., Van den Block, L., Van der Steen, J., Stichele, R., & Deliens, L. (2014). Hospitalizations of nursing home residents with dementia in the last month of life: Results from a nationwide survey. *Palliative Medicine, 28*(9), 1110-1117.

Huges, M. (2006). Affect, meaning and quality of life. *Social Forces, 85*(2), 611-629.

Hwang, D., Teno, J., Gozalo, P., & Mitchell, S. (2014). Feeding tubes and health costs post insertion in nursing home residents with advanced dementia. *Journal of pain and symptom management, 47*(6), 1116-1120.

Hwang, E. H., & Kim, K. (2021). Quality of Gerontological Nursing and Ageism: What Factors Influence on Nurses' Ageism in South Korea? *International Journal of Environmental Research and Public Health, 18*(4091), 1-13.

Illouz, E. (2007). *Cold Intimacies. The Making of Emotional Capitalism.* Cambridge: Polity Press.

Isaacson, M. (2014). Clarifying concepts: cultural humanity or competency. *Journal of Professional Nursing, 30*(3), 251-258.

Itula-Abumere, F. (2012). Should there be specific policies to protect the welfare of older people in Britain? *The Open Access Journal of Science and Technology, 1,* 1-6.

Jalilian, H., Kargar Shouroki, F., Azmoon, H., Rostamabadi, A., & Choobineh, A. (2019). Relationship between Job Stress and Fatigue Based on Job Demand-control-support Model in Hospital Nurses. *International Journal of Preventive Medicine*, 1-6.

Janowski, R. (2017, July 05). *The detention of the caregiver, who is suspected of an elderly murder, was extended. "there were signs of strangulation on the body".* Retrieved from Y NET Yediot Acharonot: https://www.ynet.co.il/articles/0,7340,L-4922252,00.html. (In Hebrew)

Jongsma, K., & Schweda, M. (2018). Return to childhood? Against the infantilization of people with dementia. *Bioethics, 32,* 414-420.

Joseph, O., Mohammed, Y., Salawu, B., Raje, A., Atolagbe, E., & Joseph, A. (2018). Role Conflict among Female Medical Career Women: Who Bridges the Gap? *Anthropological Research and Studies,* 144-154.

Karasek, R. A. (1979). Job Demands, Job Decision Latitude, and Mental Strain: Implication for Job Redesign. *Administrative Science Quarterly,* 285-308.

Karg, N., Graessel, E., Randzio, O., & Pendergrass, A. (2018). Dementia as a predictor of care-related quality of life in informal caregivers: a cross-sectional study to investigate differences in health-ralated outcomes between dementia and non-dementia caregivers. *BMG Geriatrics, 18*(189), 1-9.

Keshet, Y., & Popper-Givion, A. (2016). Work experiences of ethnic minority nurses: a qualitative study. *Israel Journal of Health Policy Research, 5*(18), 1-10.

Khagi, B., Maharjan, S., Bajracharya, S., Upadhyay, R., & Shrestha, K. (2020). Attitude of Nurses Towards Care of Elderly People in Teaching Hospitals of Kathmandu Valley. *Birat Journal of Health Sciences,* 1022-1026.

Knesset Israel. (2005). *The dying Patient bill.* Hilchot (In Hebrew).

Korkmaz Yaylagul, N., & Seedsman, T. (2012). Aging: The Common Denominator? *Population Aging, 5,* 257-279.

Kouwenhoven, P., Raijmakers, N., van Delden, J., Rietjens, J., van Tol, D., van de Vathorst, S., . . . van Thiel, G. (2015). Opinions about euthanasia and advanced dementia: a qualitative study among Dutch physicians and members of the general public. *BioMedicalCenter Medical Ethics, 16*(7), 1-6.

Kowalczuk, K., & Krajewska-Kulak, E. (2015). Influence of selected sociodemographic factors on psychosocial workload of nurses and association of this burden with absenteeism at work. *Medycyna Pracy, 66*(5), 1-8.

Kowalczuk, K., Krajewska-Kulak, E., & Sobolewski, M. (2019). Factors Determining Work Arduousness Levels among Nurses: Using the Example of Surgical, Medical Treatment, and Emergency Wards. *BioMed Research International*, 1-12.

Ku, L.-J., Pai, M.-C., & Chih, P.-Y. (2016). Economic impact of dementia by disease severity: Exploring the relationship between stage of dementia and cost of care in Taiwan. *PLOS ONE*, 1-12.

Lacher, S., Wettstein, A., Senn, O., Rosemann, T., & Hasler, S. (2016). Types of abuse and risk factors associated with elder abuse. *Swiss Medical Weekly, 146,* 1-10.

Lachs, M. S., & Pillemer, K. A. (2015). Elder Abuse. *The New England Journal of Medicine, 373,* 1947-1956.

Lagu, T., Zilberberg, M., Tjia, J., Shieh, M.-S., Stefan, M., Pekow, P., & Lindenauer, P. (2016). Dementia and Outcomes of Mechanical Ventilation. *Journal of the American Geriatrics Society, 64*(10), e63-e66.

Lenox-Smith, A., Reed, C., Lebrec, J., Belger, M., & W. Jones, R. (2016). Resource utilisation, costs and clinical outcomes in non-institutionalised patients with Alzheimer's disease: 18-month UK results from the GERAS observational study. *BioMed Central Geriatrics, 16*(195), 1-10.

Leshko, M., & Bugajska, B. (2018). Impact of environmental design on psychological and physical well-being among people with Alzheimer's Disease. *ReaearchGate*, 82-97.

Lichtner, V., Dowding, D., Allcock, N., Keady, J., Sampson, E., Briggs, M., . . . Closs, S. (2016). The assessment and management of pain in patients with dementia in hospital settings: a multi-case exploratory study from a decision making perspective. *BioMed Central Services Research, 16*(427), 1-15.

Link, B. G., & Phelan, J. C. (2006). Stigma and its public health implication. *Essay Focus, 367*, 528-529.

Linton, R. (1936). *The Study of Man.* New York: D. Appleton - Century Crofts, inc.

Livingston, G., Pitfield, C., Morris, J., Manela, M., Lewis-Holmes, E., & Jacobs, H. (2012). Care at the end of life for people with dementia living in a care home: a qualitative study of staff experience and attitudes. *International Journal of Geriatric Psychiatry, 27*, 643-650.

Luszczynska, M. (2021). *Aging as a Social Challenge. Individual. Family and Social Aspects in Poland.* London and New York: Routledge, Taylor and Francies Group.

Machado Duran Gutierrez, D., Braga Lima Sousa, A., & Grubits, S. (2015). Suicidal ideation and attempted suicide in elderly people - subjective experiences. *Ciencia & Saude Coletiva, 20*(6), 1731-1740.

Malak, R., Krawczyk-Wasielewska, A., Mojs, E., Grobelny, B., B. Gtodowska, K., Millan-Calenti, J., . . . Samborski, W. (2016). The opinion of professional caregivers about the platform UnderstAID for patients with dementia. *Medical Science Monitor, 22*, 3623-3627.

Manasatchakun, P., Chotiga, P., Roxberg, A., & Asp, M. (2016). Healthy aging in Isan - Thai culture - a phenomenographic study based on older persons' lived experiences. *International Journal of Qualitative Studies on Health and Well-being, 11*, 1 - 8.

Marcella, J., & Kelley, M. (2015). "Death is part of the job" in Long-term care homes: supporting direct care staff with their grief and bereavement. *SAGE Open*, 1-15.

Martin, L. S., Gillies, L., Coker, E., Pizzacalla, A., MonteMuro, M., Suva, G., & McLelland, V. (2016). An Education Intervention to Enhance Staff Self-efficacy to Provide Dementia Care Hospital in Canada: A non randomized Controlled Study. *Current Topics in Research*, *31*(8), 664-677.

Martins, R., Neto, M. J., Andrade, A., & Albuquerque, C. (2014). Abuse and maltreatment in the elderly. *Atencion primaria*, *46*, 206-209.

Martinsson, L., Lundstrom, S., & Sundelof, J. (2018). Quality of end-of-life care in patients with dementia compared to patients with cancer: A population-based register study. *PLOS ONE*, 1-11.

Mead, M. (1973). *Coming of age in Samoa. A psychological study of primitive youth for Western civilization.* New York: William Morrow & Company.

Melchiorre, M. G., Di Rosa, M., Barbabella, F., Barbini, N., Lattanzio, F., & Chiatti, C. (2017). Validation of the Italian Version of the Caregiver Abuse Screen among Family Caregivers of Older People with Alzheimer's Disease. *BioMed Research International*, 1-15.

Mendiratta, P., Tilford, J., Prodhan, P., Curseen, K., Azhar, G., & Wei, J. (2014). Trends in Percutaneous endoscopic Gastrostomy Placement in the elderly from 1993 to 2003. *American Journal of Alzheimer's Disease and Other Dementias*, *27*(8), 609-613.

Mercante, O., Gagliardi, C., Spazzafumo, L., Gaspari, A., David, S., Cingolani, D., . . . Silvaroli, R. (2014). Loss of autonomy of hospitalized elderly patients: does hospitalization increase disability? *European Journal of Physical and Rehabilitation Medicine*, *50*, 703-708.

Mobula, L. M., Okoye, M. T., Boulware, L., Carson, K. A., Marsteller, J. A., & Cooper, L. A. (2014). Cultural competence and perceptions of community health workers' effectiveness for reducing health care disparities. *Journal of Primary Care & Community Health*, 1-6.

Mogan, A. (2017). Medical Paternalism: Still Alive in English Law? *University of Southampton Student Law Review*, *7*, 29-34.

Mollenkopf, H., Walker, A., Bowling, A., Daatland, S. O., Hansen, T., Antonucci, T. C., . . . Sixsmith, A. (2007). *Quality of life in old age. International and Multi-Disciplinary perspectives.* (H. Mollenkopf, & A. Walker, Eds.) The Netherlands: Springer.

Monroe, T. B., Herr, K. A., Mion, L. C., & Cowan, R. L. (2012). Ethical and legal issues in pain research in cognitively impaired older adults. *International Journal of Nursing Studies, 50*(9), 1-9.

Moore, K., Candy, B., Davis, S., Gola, A., Harrington, J., Kupeli, N., . . . Sampson, E. (2017). Implementing the compassion intervention, a model for integrated care for people with advanced dementia towards the end of life in nursing homes: a naturalistic feasibility study. *BMJ Open Access, 7*, 1-15.

Mottus, R., Gale, C. R., Starr, J. M., & Deary, I. J. (2012). "On the street where you live": Neighbourhood deprivation and quality of life among community-dwelling older people in Edinburgh, Scotland. *Social Science & Medicine, 74*, 1368 - 1374.

Murgis, L., Hebert, P. C., Sovic, S., & Pavlekovic, G. (2015). Paternalism and autonomy: views of patients and providers in a transitional (post-communist) country. *BMC Medical Ethics, 16*(65), 1-9.

Murphy, K., Liu, W., Goltz, D., Fixsen, E., Kirchner, S., Hu, J., & White, H. (2019). Implementation of personalized music listening for assisted living residents with dementia. *Geriatric Nursing, 39*(5), 560-565.

Napier, D., Ancarno, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., . . . Woolf, K. (2014). Culture and health. *The Lancet Commissions, 384*, 1607-1639.

Nicolas, L. H. (2014). Advance directives and nursing home stay associated with less aggressive end-of-life care for severe dementia patients. *National Institutes of Health, 33*(4), 667-674.

Nirel, N., Grinstien-Cohen, O., Eyal, Y., Samuel, H., & Ben-Shoham, A. (2015). Models for projecting supply and demand for nurses in Israel. *Israel Journal of Health Policy Research, 4*(46), 1-12.

Olsen, C., Pedersen, I., Bergland, A., Enders-Slegers, M.-J., Joranson, N., Calogiuri, G., & Ihlebak, C. (2016). Differences in quality of life in home-dwelling persons and nursing home residents with dementia-a cross-sectional study. *BioMed Central Geriatrics, 16*(137), 1-11.

Olshansky, S. J. (2016). Measuring our narrow strip of life. *Nature*(538), 175 - 176.

Ostrom, T. M. (1969). The Relationship between the Affective, Behavioral, and Cognitive Components of Attitude. *Journal of Experimental Social Psychology, 5*, 12-30.

Panagopoulou, E., Montgomery, A. J., & Tsiga, E. (2015). Bringing the well-being and patient safety research agenda together: why healthy HPs equal safe patients. *Frontiers in Psychology*(6), 1-3.

Parsons, T. (1951). *The Social System.* New York: American Book-Knickerbocker Press.

Pedrazza, M., Berlanda, S., Trifiletti, E., & Bressan, F. (2016). Exploring physicians' dissatisfaction and work-related stress: development on the PhyDis scale. *Frontiers in Psychology, 7*, 1-13.

Pejner, M. N., Ziegert, K., & Kihlgren, A. (2012). Trying to cope with everyday life - emotional support in municipal elderly care setting. *International journal of qualitative studies on health and well-being*, 1-7.

Pekince, H., Aslan, H., Erci, B., & Akturk, U. (2018). The attitudes of healthcare professionals in a state hospital towards ageism. *Journal of Public Health: From Theory to Practice, 26*, 109-111.

Philips, C. (2016). Integrating estimates of the social and individual costs of caregiving into dementia treatment trials. *Health Services Insights*, *9*, 1-2.

Pillemer, K., Burnes, D., Riffin, C., & Lachs, M. S. (2016). Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies. *The Gerontological Society of America*, *56*(s2), 194-205.

Pohontsch, N. J., Scherer, M., & Eisele, M. (2017). (In-)formal caregivers' and general practitioners views on hospitalizations of people with dementia - an exploratory qualitative interview study. *BMC Health Services Research, 17*(530), 1-13.

Rezende, D. F., Oliveira, G. N., Vianna, L. G., & dos Santos, I. B. (2014). Euthanasia: would elderly people from socio-economic classes D/E perform it or allow it on their relatives? *Journal Kairos Gerontologia*, *17*(17), 125-135.

Roen, I., Kirkevold, O., Testad, I., Selbak, G., Engedal, K., & Bergh, S. (2018). Person-centered care in Norwegian nursing homes and its relation to organizational factors and staff characteristics: a cross-sectional survey. *International Psychogeriatrics*, *30*(9), 1279-1290.

Rogers, C. R. (1959). A Theory of Therapy, Personality, and Interpersonal Relationships, as Developed in the Client-Centered Framework. In S. Koch (Ed.), *Psychology: A Study of a Science. Formulation of the Person and the Social Context* (Vol. 3, pp. 184-256). New York: McGraw-Hill.

Rogers, C. R. (1961). *On Becoming a Person. A therapist's view of psychotherapy.* Boston: Houghton Mifflin Company.

Rosato, M., Leavey, G., Cooper, J., De Cock, P., & Devine, P. (2019). Factors associated with public knowledge of and attitudes to dementia: A cross-sectional study. *PLOS ONE*, *14*(2), 1-13.

Rosen, T., Bloemen, E. M., LoFaso, V. M., Clark, S., Flomenbaum, N., & Lachs, M. S. (2016). Emergency Department Presentation for Injuries in Older Adults

Independently Known to be Victims of Elder Abuse. *The Journal of Emergency Medicine, 50*(3), 518-526.

Rosenberg, A. (2017, August 08). *Why are those aged 75 and over ranked first in suicide attacks in Israel*. Retrieved from Y NET Yediot Acharonot: https://www.ynet.co.il/articles/0,7340,L-5000173,00.html (In Hebrew)

Rosochacka-Gmitrzak, M. (2016). Age friendly cities and communities: dream or reality? *Section Sociology and Healthcare*, 95-101.

Ruelas-Gonzalez, M. G., Duarte-Gomez, M. B., Flores-Hernandez, S., Ortega-Altamirano, D. V., & Cortes-Gil, J. D. (2016). Prevalence and factors associated with violence and abuse of older adults in Mexico's 2012 National Health and Nutrition Survey. *International Journal for Equity in Health, 15*(35), 1-9.

Rulling according to, 4. (2009, 12 29). *Shlomo raab vs the State of Israel*. Retrieved from Rulling: http://www.ruling.co.il/%D7%A2%22%D7%A4-4688-09-%D7%A9%D7%9C%D7%9E%D7%94-%D7%A8%D7%90%D7%91-%D7%A0.-%D7%9E%D7%93%D7%99%D7%A0%D7%AA-%D7%99%D7%A9%D7%A8%D7%90%D7%9C_c5b4909f-c2e1-2ae5-7afa-51ddb4c52efcl (In Hebrew)

Ruokangas, S.-M., Weiste, E., Ervasti, J., Oksanen, T., & Nieminen, P. (2020). Job demands and job control among occupational therapists in public sector in Finland. *Scandinavian Journal of Occupational Therapy*, 1-10.

Rzeszut, S. M. (2017). The need for a stronger definition: recognizing abandonment as a form of elder abuse across the United States. *Family Court Review*, 444-457.

Sanchez-Izquierdo, M., Santacreu, M., Olmos, R., & Fernandez-Ballesteros, R. (2019). A training intervention to reduce paternalistic care and promote autonomy: a preliminary study. *Clinical Interventions in Aging, 14*, 1515-1525.

Scala, R. (2016). Challenges on non-invasive ventilation to treat acute respiratory failure in the elderly. *BioMedCentral Pulmonary Medicine, 16*, 1-10.

Scazufca, M., P. de Paula Couto, M. C., Huang, H., Kester, R., Braga, P. E., T.P.Peluso, E., . . . Ribeiro, E. (2016). Public Stigma towards Older Adults with Depression: Findings from the Sao Paulo - Manaus Elderly in Primary Care Study. *PLOS ONE, 11*(6), 1-17.

Schroder, S. L., Fink, A., Schumann, N., Moor, I., & Plehn, A. (2015). How socioeconomic inequalities impact pathways of care for coronary artery disease among elderly patients: study protocol for a qualitative longitudinal study. *BMJ, 15*, 1-7.

Schwendimann, R., Dhaini, S., Ausserhofer, D., Engberg, S., & Zuniga, F. (2016). Factors associated with high job satisfaction among care workers in Swiss nursing homes - a cross sectional survey study. *BioMedCentral Nursing, 15*(37), 1-10.

Sedri, N., Zakeri, M. A., Zardiny, M. Z., & Tavan, A. (2022). Evaluation of Nurses' Knowledge and Attitudes toward Older Adults and Assciated Factors. *The Open Nursing Journal*(16), 18.

Sewilam, A. M., Watson, A. M., Kassem, A. M., Clifton, S., McDonald, M. C., Lipski, R., . . . Nimgaonkar, V. L. (2015). Roadmap to reduce the stigma of mental illness in the Middle East. *The International journal of social psychiatry, 61*(2), 111-120.

Shahak, M. K. (2015). *In honor of MK Itzik Shmueli. Re: Data on violence against the elderly in Israel in 2010-2014 (In Hebrew).*

Shaw, R. L., West, K., Hagger, B., & Holland, C. A. (2016). Living well to the end: A phenomenological analysis of life in extra care housing. *International Journal of Qualitative Studies on Health and Well-Being, 11*, 1 - 12.

Sherif Trask, B. (2010). *Globalization and families. Accelerated Systemic Social Change.* London: Springer.

Skoldunger, A., Fastbom, J., Wimo, A., Fratiglioni, L., & Johnell, K. (2016). The Impact of dementia on drug costs in older people: Results from the SNAC study. *BMC Neurology, 16*(28), 1-9.

Skountridaki, L. (2019). The patient-doctor relationship in the transnational healthcare context. *Sociology of Health & Illness, 41*(8), 1685-1705.

Smebye, K., Kirkevold, M., & Engedal, K. (2016). Ethical dilemmas concerning autonomy when persons with dementia wish to live at home: a qualitative, hermeneutic study. *BMC Health Services Research, 16*(21), 1-12.

Smith, C. M., Lane, S. H., Brackney, D. E., & Horne, C. E. (2020). Role expectations and workplace relations experienced by men in nursing: A qualitative study through an interpretive description lens. *Journal of Advanced Nursing*(76), 1211-1220.

Smith, J., Sawhney, M., Duhn, L., & Woo, K. (2022). The Association Between New Nurses' Gerontological Education, Personal Attitudes Toward Older Adults, and Intentions to Work in Gerontological Care Settings in Ontario, Canada. *Canadian Journal of Nursing Research, 54*(2), 190-198.

Soderberg, M., Stahl, A., & Emilsson, U. M. (2012). Family members' strategies when their elderly relatives consider relocation to aresidential home-adopting, representing and avoiding. *Journal of Aging Studies, 26*, 495-503.

Sontag, S. (1978). *Illness as Metaphor.* New York: Farrar, Status and Giroux.

Sontag, S. (1989). *Aids and it's Metaphor.* New York: Farrar, Straus and Giroux.

Soreide, K., & F Desserud, K. (2015). Emergency surgery in the elderly: the balance between function, frailty and futility. *Trauma, Resuscitation and Emergency Medicine, 23*(10), 1-7.

Srinivas, G., Kuma, S., Mohanraj, R., Sekkizhar, G., Muthuvel, T., Lal, V., . . . Kasang, C. (2018). Development and validation of a scale to assess attitude of health care providers towards persons affected by leprosy in southern India. *PLOS Neglected Tropical Diseases*, 1-15.

Srivastava, G., Kumar Tripathi, R., Grandra Tiwari, S., Singh, B., & Mohan Tripathi, S. (2016). Caregiver burden and quality of life of key caregivers of patients with dementia. *Indian journal of psychological medicine, 38*(2), 133-136.

St John, K., & Koffman, J. (2017). Introducing Namaste Care to the Hospital Environment: a pilot study. *Annals of Palliative Medicine, 6*(4), 354-364.

Steinberg, A. (2003, January). *The Halachic basis for the proposed "The dying patient law". Retrieved from Da'at - the site of Jewish Studies and Spirit*. Retrieved from Herzog College: http://www.daat.ac.il/daat/kitveyet/assia/habasis-2.htm (in Hebrew)

Sternbach, A. (2017, February 05). *Elderly cuffed and beaten: horror in filmed in nursing homes*. Retrieved from Y NET Yediot Aharonot: https://www.ynet.co.il/articles/0,7340,L-4917998,00.html (In Hebrew)

Sullivan, C. G. (1993). Towards clarification of convergent concepts: sense of coherence, will to meaning, locus of control, learned helplessness and hardiness. *Journal of Advanced Nursing, 18*, 1772-1778.

Sullivan, G. (2005). Margaret Mead's individual in culture, or cultures and personalities without embarrassment. *28*, 91-105.

Tanajewski, L., Franklin, M., Gkountouras, G., Berdunov, V., Harwood, R., Goldberg, S., . . . Elliott, R. (2015). Economic evaluation of a general hospital unit for older people with delirium and dementia (TEAM Randomised Controlled Trial). *PLOS ONE*, 1-20.

Teaster, P. B., Ramsey-Klawsnik, H., Abner, E. L., & Kim, S. (2015). Investigation of the Sexual Victimization of Older Women Living in Nursing Homes. *Journal of elder abuse & neglect, 27*(4-5), 392-409.

Teno, J., Gozalo, P., Khandelwal, N., Curtis , R., Meltzer, D., Engelberg, R., & Mor, V. (2016). Association of increasing use of mechanical ventilation among nursing home residents with advanced dementia and intensive care unit beds. *JAMA Internal Medicine, 176*(12), 1809-1816.

Thorsteinsdottir, B., Swetz, K., & Albright, R. (2015). The ethics of chronic dialysis for the older patient: time to reevaluate the norms. *Clinical journal of the American Society of Nephrology, 10*, 2094-2099.

Thyrian, J. R., & Hoffmann, W. (2012). Dementia care and general physicians - a survey on prevalence, means, attitudes and recommendations. *Central European Journal of Public Health, 20*(4), 270-275.

Topaz, M. (2009, November). The ageism among nurses in Israel: the attitudes toward elderly in emergency departments in hospitals. Haifa, Israel: The Haifa University.

Trachtenberg, A. J., & Manns, B. (2017). Cost analysis of medical assistance in dying in Canada. *CMAJ, 189*(3), E101-E105.

Tripodi, D., Roedlich, C., Laheux, M. A., Longuenesse, C., Roquelaure, Y., Lombrail, P., & Geraut, C. (2012). Stress perception among employees in a French University Hospital. *Occupational Medicine*(62), 216-219.

Tsai, C.-F., Lee, Y.-T., Lee, W.-J., Hwang, J.-P., Wang, S.-J., & Fush, J.-L. (2015). Depression of family caregivers is associated with disagreements on life-sustaining preferences for treating patients with dementia. *PLOS ONE,* 1-11.

Van der Dam, S., Abma, T., Kardol, M., & Widdershoven, G. (2012). "Here's my dilemma"/ Moral case Deliberation as a platform for discussing everyday ethics in elderly care. *Health care analysis: HCA: journal of health philosophy and policy, 20*, 250-267.

Van der Heijden, B., Brown Mahoney, C., & Xu, Y. (2019). Impact of Job demands and Resources on Nurses' Bornout and Occupational Turnover Intention Towards an Age-Moderated Mediation Model for the Nursing Profession. *international Journal of Environmental Research and Public Health, 16*(2011), 1-22.

Van Ryn, M., Burgess, D. J., Dovidio, J. F., Phelan, S. M., Saha, S., Malat, J., . . . Perry, S. (2011). The Impact of Racism on Clinician Cognition, Behavior, and Clinical Decision Making. *Du Bois Review, 8*(1), 199-218.

Van Wijngaarden, E., J. W. Leget, C., & Goossensen, A. (2016). Till Death Do Us Part: The Lived Experience of an Elderly Couple Who Chose to End Their Lives by Spousal Self - euthanasia. *The Gerontological Society of America, 56*(6), 1062-1071.

Van Wijngaarden, E., Leget, C., & Goossensen, A. (2015). Ready to give up on life: The lived experience of elderly people who feel life is completed and no longer worth living. *Social Science & Medicine, 138*, 257-264.

Wandrowski, J., Schuster, T., Wolfgang, S., & Steger, F. (2012). Medical ethical knowledge and moral attitudes among physicians in Bavaria. *Medicine, 109*(8), 141-147.

Wang, J., Liu, W., Wang, H., Zhao, Q., & Xiao, M. (2022). Difference of Physical Restraint Knowledge, Attitude and Practice Between Nurses and Nursing Assistants in Long-Term Care Facilities: A Cross-Sectional Study. *Risk Management and Healthcare Policy*(15), 243-255.

Wang, X. M., Brisbin, S., Loo, T., & Straus, S. (2015). Elder abuse: an approach to identification, assessment and intervention. *CMAJ, 187*(8), 575-581.

Weber, M. (1978). Part one: conceptual exposition. IV Status Groups and Classes. In R. Guenther , & C. Wittich (Eds.), *Economy and Society* (E. Fischoff, H. Gerth, A. M. Henderson, F. Kolegar, C. W. Mills, T. Parsons, . . . C. Wittich , Trans., pp. 302-310). Berkeley, Los Angeles, London: University of California Press.

Weinberger, L. E., Sreenivasan, S., & Garrick, T. (2014). End-of-Life Mental Health Assessments for Older Aged, Medically Ill Persons With Expressed Desire to Die. *The Journal of the American of Psychiatry and the Law, 42*(350), 350-361.

Werner, P., & Doron, I. (2017). Alzheimer's disease and the law: positive and negative consequences of structural stigma and labeling in the legal system. *Aging & Mental Health, 21*(11), 1206-1213.

Werner, P., & Shpigelman, C. N. (2019). Family caregivers' and professionals' stigmatic experiences with persons with early-onset dementia: a qualitative study. *Scandinavian Journal of Caring Sciences*, 1-10.

Werner, P., Abo Jabel, H., Reuveni, Y., & Prilutzki, D. (2017). Stigmatic Beliefs Toward a Person with Alzheimer's Disease Among High-school Students: Does Majority-minority Status Make a Difference. *Educational Gerontology, 43*(12), 609-618.

Werner, P., Kalaitzaki, A. E., Spitzer, N., Raviv-Turgeman, L., Koukouli, S., & Tziraki, C. (2019). Stigmatic Beliefs towards Persons with Persons with Dementia: Comparing Israeli and Greek College Students. *International Psychogeriatrics, 31*(10), 1393-1402.

Wharton, T., & Ford, B. K. (2014). What is Known About Dementia Care Recipient Violence& Aggression Against Caregivers. *Journal of gerontological social work, 57*(5), 460-477.

White, S. (2014). Ethical and legal aspects of anesthesia for the elderly. *Anesthesia, 69*(1), 43-45.

WHOQOL Group. (1998). Development of the World Health Organization WHOQOL - BRIEF quality of life instrument. *Psychological medicine, 28*, 551-558.

Willemse, B. M., De Jonge, J., Smit, D., Visser, Q., Depla, M. F., & Pot, A. M. (2014). Staff's person-centredness in dementia care in relation to job characteristics and job-related well-being: a cross-sectional survey in nursing homes. *Informing Practice and Policy Worldwide through Research and Scholarship*, 404-416.

Wills, J., Kelly, M., & Frings, D. (2019). Nurses as role models in health promotion: Piloting the acceptability of a social marketing campaign. *Journal of Advanced Nursing*(75), 423-431.

Wittenberg, R., & Hu, B. (2016). The impact of Alzheimer's disease in China. *EBioMedicine, 4*, 22-23.

Wong, N. Z., Rosen, T., Sanchez, A. M., Bloemen, E. M., Mennitt, K. W., Hentel, K., . . . Lachs, M. S. (2017). Imaging Findings in Elder Abuse: A Role for Radiologists in Detection. *Canadian Association of Radiologists Journal, 68,* 16-20.

Woo, B. K. (2017). Family history and its relationship with dementia stigma beliefs among Chinese Americans. *Geriatrics & Gerontology International, 17*, 122-25.

Ying, I., Levitt, Z., & Jassal, S. (2014). Should an elderly patient with stage V CKD and dementia be started on Dialysis. *The American Society of Nephrology, 9*, 971-977.

Yon, Y., Mikton, C. R., Gassoumis, Z. D., & Wilber, K. H. (2017). Elder abuse prevalence in community settings: a systematic review and meta-analysis. *The Lancet. Global health, 5*, e147-156.

Yunus, R. M., Wazid, S. W., Hairi, N. N., Choo, W. Y., Hairi, F. M., Sooryanarayana, R., . . . Awang Mahmud, A. B. (2017). Association between elder abuse and poor sleep: A cross-sectional study among rural older Malaysians. *PLOS one*, *12*(7), 1-14.

Zimmerman, S., Dobbs, D., Roth, E. G., Goldman, S., Peeples, A. D., & Wallace, B. (2016). Promoting and Protecting Against Stigma in Assisted Living and Nursing Homes. *The Gerontologist*, 535-47.

Zimmermann, M. (2017). Alzheimer's Disease Metaphors as Mirror and Lens to the Stigma of Dementia. *Literature and Medicine, 35*(1), 71-97.

Zufiaurre, B., & Perez de Villarreal, M. (2008). Researching Gender Professions: Nurses as Professionals. *Journal of Curriculum and Teaching, 7*(1), 197-205.

10. Appendixes:

Appendix 1: Worksheet for the Mediator of the Focus Groups:

Main Topic

Elderly patients with dementia and their care.

Research Question

What are the attitudes of caregivers regarding the quality of care given to elderly patients with dementia in old age homes and hospital wards in Israel?

Guidelines for the Management of the Focus Group

General Guidelines

- Focus group: Guided discussion of an hour and a half to two hours. Every group consists of six to eight participants.
- Every participant has the right to express his or her opinion.
- Every participant is assured confidentiality.
- The participation in the research is voluntary.
- Every participant has the right to leave at any time.
- The discussion will be recorded. The recording will be saved on the researcher's personal computer.
- The participants are asked to behave respectfully towards one another. Every opinion voiced in the discussion is accepted and appreciated.

Questions for the Guided Discussion

- What is the general position of the participants regarding the quality of the care that is given to the elderly in general and to the elderly with dementia in particular in the medical institutions in Israel?
- What is the position of the participants in the discussion regarding the performance of invasive medical actions (such as gastrostomy, intubation, dialysis, surgery, etc.) that extend life without improving the quality of life of elderly dementia patients?
  - ✓ What are the factors in the participants' opinion that influence the carrying out of invasive actions in old age?
  - ✓ What are the factors that should be taken into consideration?
- What is the meaning that every participant attributes to the concept of "dying with dignity" regarding the elderly in general and the elderly patients with dementia?
- How is the concept of "quality of life" among elderly patients with dementia perceived among the participants?
- Is it possible to address the topics of "end-of-life plans" and "the desire of the elderly person"?

What needs to be done to provide high-quality care for the elderly and the elderly with dementia?

Appendix 2: General description of the research group:

a. Gender:

Gender	Participants	Rate (%)
Male	2	4
Female	45	96
Total	47	100

b. Religion:

Religion	Participants	Rate (%)
Jews	23	49
Muslims	17	36
Christians	7	15
Total	47	100

c. Division of nurses by departments:

Departments	Participants	Rate (%)
Other	3	6
Combination of two departments	5	11
Emergency	7	15
Geriatrics	10	21
Internal	22	47
Total	47	100

d. Nurse position:

Nurse position	Participants	Rate (%)
Senior nurse	4	8
Nurse assistant	6	13
Management position	9	19
Registered nurse	28	60
Total	47	100

e. Academic education:

Academic education	Participants	Percentage Rate (%)
High School	6	13
BA	28	59
MA	13	28
Total	47	100

f. Professional courses:

Professional courses	Participants	Percentage Rate (%)
Advanced professional training	15	32
NO Advanced professional training	27	57
Clinical teacher course	5	11
Total	47	100

g. Years of nurse's work experience:

Years of work experience	Participants	Percentage Rate (%)
0-1	2	4
1-5	7	15
5-10	13	28
10-15	13	28
15-20	10	21
Over 20	2	4
Total	47	100