The 2007 Atkinson Fellowship in Public Policy

Boomer Tsunami: Ready or Not
A Special Report by Judy Steed

Ontario braces for a grey wave

SPECIAL REPORT:

It's been called a "demographic tsunami," the population bulge of baby boomers closing in on their senior years. Whether the mass of them spend their final years in dignity or "stacked like cordwood" in institutions depends on decisions being made now. Will we be ready?

RENE JOHNSTON/TORONTO STAR

Look closely and you will see clues that this nursing home is not in Canada. Wine on the table, for a start. Several residents sitting at their tables smoking. This is Lotte, the most famous nursing home in Denmark, where Ida Dupont, 94, gets ready to lead the dancing after Saturday night dinner. Denmark is one of the best countries in the world in which to grow old.

In Toronto's literary and cultural circles, she is a strong presence - the internationally respected Phyllis Grosskurth, Ph.D., Order of Canada, English professor and author of acclaimed biographies of John Addington Symonds, Havelock Ellis, Melanie Klein and Byron. She also wrote The Secret Ring: Freud's Inner Circle and the Politics of Psychoanalysis.

Grosskurth, 83, had a stroke seven years ago.

"They say I'll never walk again," she says, calmly - as elegant as ever, sharply defined by her wry humour and inimitable approach to life. She's still got her "eagle eye," loves to gossip, ferret out stories, ask blunt questions.

Did she learn anything useful from her studies of psychoanalysis, anything helpful for this stage of her life?

"Yes, I did." She pauses. "Acceptance. It means I'd love to be young, to be swimming, to be cooking and gardening, but I can't do any of those things any more. There are compensatory things."

Such as?

"Voltaire said, 'Cultivate your garden.'"

Aging - it's better than the alternative. And the older we get, it seems, the longer we *want* to live - and, indeed, *are* living.

"There's a demographic tsunami headed our way," says the University of Toronto's Dr. Alejandro Jadad, a physician with a special interest in public health. Like almost every other developed country, Canada is greying, big-time, as the population bulge known as baby boomers closes in on senior status, with the first wave turning 65 in 2011. They will live longer than their forebears; not only has Canadian life expectancy doubled in the past century, to 82 for men and 85 for women, but many more of us will live to be 100.

By 2050, a quarter of Canada's population will be 65 or older.

What on earth will we do with all the elders? Stack them, bunk-bed style, in the province's 622 nursing homes? Cut them loose on melting ice floes?

Many critics lambaste Ottawa for its failure to develop a national strategy to cope with the massive numbers of aging Canadians or to create a national home-care program for seniors.

Ian McDowell, the epidemiologist who led the federally funded Canadian Study of Health and Aging - the world's largest study on the prevalence of dementia - says Ottawa's policy-makers haven't got a clue.

McDowell's team looked at 10,263 people, aged 65 and older between 1991 and 2001, and found that by age 85, one-third of us will have dementia - a range of brain diseases including Alzheimer's. They also identified risk factors and preventive measures.

But McDowell says he was unable to elicit much interest from federal policy-makers.

"They appeared to be completely unable to identify a single policy that could be useful in relation to seniors and aging." On one of the "major issues of our time," as he puts it, Canada's federal government was "deaf."

About a week after the stroke, Grosskurth asked a hospital intern about her future prospects. "I kept nagging him about my condition. Would I recover? Finally, he said to me, 'I think you'll be in a wheelchair for the rest of your life and never be able to get out of bed on your own again.' That hit me hard. My children were quite angry at him."

Grosskurth's husband of 28 years, Bob McMullan, 84, set about adapting their cozy Cabbagetown home to their new life. "No sensible person would have tried to retrofit an 1870 Victorian semi-detached cottage," he says cheerfully. They went ahead and did it: a discreet ramp at the front door for her wheelchair; a ground floor washroom built off the kitchen - "I lost my pantry," Grosskurth says. A chair lift was added to the side of the narrow stairs; grab bars in the upstairs bathroom; a floor-to-ceiling pole beside the bed. "I didn't want the pole," Grosskurth says, "but it's very useful." When McMullan helps her out of bed, she can brace herself against the pole.

He laughs about their "crazy optimism. We believe in mission impossible."

Ontario has a serious problem: health care consumes $40.4 billion of the province's $96-billion budget. Its 157 hospitals receive $18.4 billion. Despite massive spending, the system is overburdened with wait lists, emergency rooms clogged with old people and "bed blockers" - seniors stuck in hospital, at a cost of $200 million a year, because home care is inadequate and nursing homes are full.

Former health minister George Smitherman took decisive action last year by introducing the Aging at Home initiative, which has expanded from $700 million over three years to $1.1 billion over four years to help seniors remain independent in the community as long as possible.

Nicknamed "Furious George" for his often-aggressive style, Smitherman needed every ounce of tenacity to turn around the Titanic. Redirecting the focus of the health care system - along with money and power - away from hospitals and institutions to the community sector has been no easy task.

"I think of the hospital as the goalie of the hockey team," says Hy Eliasoph, a prominent health-care administrator. "In the past, we invested in the goalie, gave him the best possible equipment - just as we poured resources into hospitals and starved the community. Now we need a strong offence, a strong focus on primary care, prevention and health promotion, with home care as the defence."

The shift in Ontario policy makes perfect sense as baby

Atkinson Fellowship winner Judy Steed has spent much of the last year sitting at kitchen tables, on living room couches and on the edges of beds. She has interviewed hundreds of seniors, challenged policy-makers and learned from academics to present this compelling portrait of aging in Ontario. Infused with a deep caring for older people, Steed's analysis of what awaits us, and how prepared we are for it, will alarm, inform ... and move you to tears.

Awarded yearly to an experienced, full-time Canadian journalist, The Atkinson Fellowship in Public Policy is designed to further the tradition of liberal journalism and commitment to social and economic justice fostered by Joseph E. Atkinson, former publisher of the Toronto Star.

There's dignity in aging at home

boomers enter their later years, says Shirlee Sharkey, president and CEO of Saint Elizabeth Health Care, a not-for-profit that provides a wide array of home care services to Ontarians.

"Older seniors are typically more accepting," she says. "Younger seniors - the boomers - are more assertive. For them - for us - it's a given that we're staying at home as we age; nobody's going to ship us off to nursing homes when we're not ready to go."

Ontario has 75,973 beds in nursing homes, and it costs $43,000 per person per year for a place in long-term care.

By contrast, the annual price tag of home care is about $3,000.

"There's a sense of optimism in Ontario today," says Margaret MacAdam, a Toronto gerontologist. "Our health-care system is being transformed to care for people at home, in the community, as they age, and we don't know what will work *exactly*.

"No country has a perfect system, not even Sweden and Denmark. They're the gold standard. They're worried about sustainability, as we are - but we're reaching for it."

Health Minister David Caplan took over stewardship of Aging at Home when Smitherman became Minister of Energy and Infrastructure in June. "George did a lot of heavy lifting around system reform," he says.

As Caplan sees it, his job is to ensure that the system advances swiftly, keeping its focus on what seniors want and identifying "best practices" to be applied across the province."I want to support

It's a given that boomers won't want to be shipped off to nursing homes

a health-care system that allows people to take risks and try new things. Innovation should be a hallmark."

To enable communities to make decisions about health care locally, in 2006 the Ontario government divided the province into 14 Local Health Integration Networks (LHINS), aligned with 14 Community Care Access Centres (CCACs), which provide free home care from cradle to grave and control access to long-term care facilities.

If Grosskurth went into a nursing home, "I would want to go as well," McMullan says. "We're taking the riskier route; it's more life enhancing. We're not going to leave our home until we absolutely have to."

Says Grosskurth: "Some people give up when they're told they can't walk. I have physio once a week. We're working on me standing." A personal support worker comes four days a week from the Community Care Access Centre, for two hours a day. Grosskurth is one of the lucky ones: she can afford to pay for an additional helper to come three days a week while McMullan is at work.

"Some people give up when they're told they can't walk," says Phyllis Grosskurth, shown with husband Bob McMullan."I have physio once a week. We're working on me standing."

Does the Community Care Access Centre provide a sense of security? "No. The PSWs from the CCAC are not trained, they often can't speak English well and have trouble comprehending what I'm saying," Grosskurth says. "It's stressful, trying to explain what I need, having to deal with a different person all the time. The days Lucille (her private caregiver) comes are glory days for me. She knows what to do, she knows what I like, and she's reliable."

As for the CCAC's policy on wait lists for nursing homes, Grosskurth and McMullan think it's all wrong. "We put our name down for Belmont House and a place came up," McMullan says. "We said no - we weren't ready to go - and the woman warned us, 'There are an awful lot of people who want to get in to Belmont House.' The truth is many people go to nursing homes when they really don't have to." The CCAC should change its wait list policy so that "you don't have to jump at a room when you could still be living at home," he says." Isn't that what the government is trying to encourage?"

"No sensible person would have tried to retrofit an 1870 Victorian semi-detached cottage," Bob McMullan says of adapting their home for his wife.

The first major initiative for the LHINs is Aging at Home. It will be delivered through the CCACs and community agencies - such as St. Christopher House or Mid-Toronto Community Services - that provide home-delivered and communal meals, recreational and social activities, and transportation.

The CCAC system is incredible in its reach - every day, the province's 14 CCACs are in contact with 200,000 clients, linked to 158 hospitals, 622 long-term-care facilities and thousands of community support agencies.

With a staff of 7,000 across Ontario and a budget of $1.7 billion for 2008/09, CCACs procure and manage the delivery of services from both non-profit and private agencies, including nursing, physiotherapy, nutrition counselling, occupational therapy, personal support, housekeeping, transportation, palliative care, and in-home diagnostic and lab procedures and dialysis.

In the new year, a new telephone number will be launched (310-CCAC) as a one-stop shop for home-care services.

Before you can get free services, a CCAC case manager must visit you to assess your needs, approve you and develop a personal care plan - which could include personal support, grab bars in your bathroom, or nursing services, if needed. "As long as you've got a health card, we'll provide free services that are paid for by OHIP," says Margaret Mottershead, former deputy minister of health and now CEO of the province's Association of CCACs.

The CCAC can also refer you to community agencies for day programs or Meals on Wheels - which will cost you about $5 per meal.

"We don't want to come in and take over your life," she notes.

BY THE NUMBERS

According to Statistics Canada, the number of people 65 and older is expected to reach 6.7 million by 2021. Twenty years later, that figure will climb to 9.2 million, with 1.6 million age 85 and older. Meanwhile, the proportion of children and young people is expected to continue declining for another half-century.

The Ontario Ministry of Finance forecast in 2006 there were about 1.6 million people age 65 and older in Ontario, accounting for 13 per cent of the12.7-million population. That seniors group will more than double to 3.5 million — representing more than 21 per cent of the province's population — by 2031.

"We're partnering with you - that's the tone. If you can't make calls to arrange appointments, we'll help you."

Camille Orridge, head of the Toronto Central CCAC, says the focus is on the individual. "It's not a cookie-cutter approach. You get what you need, based on your condition, and we work with you to maximize all possible resources."

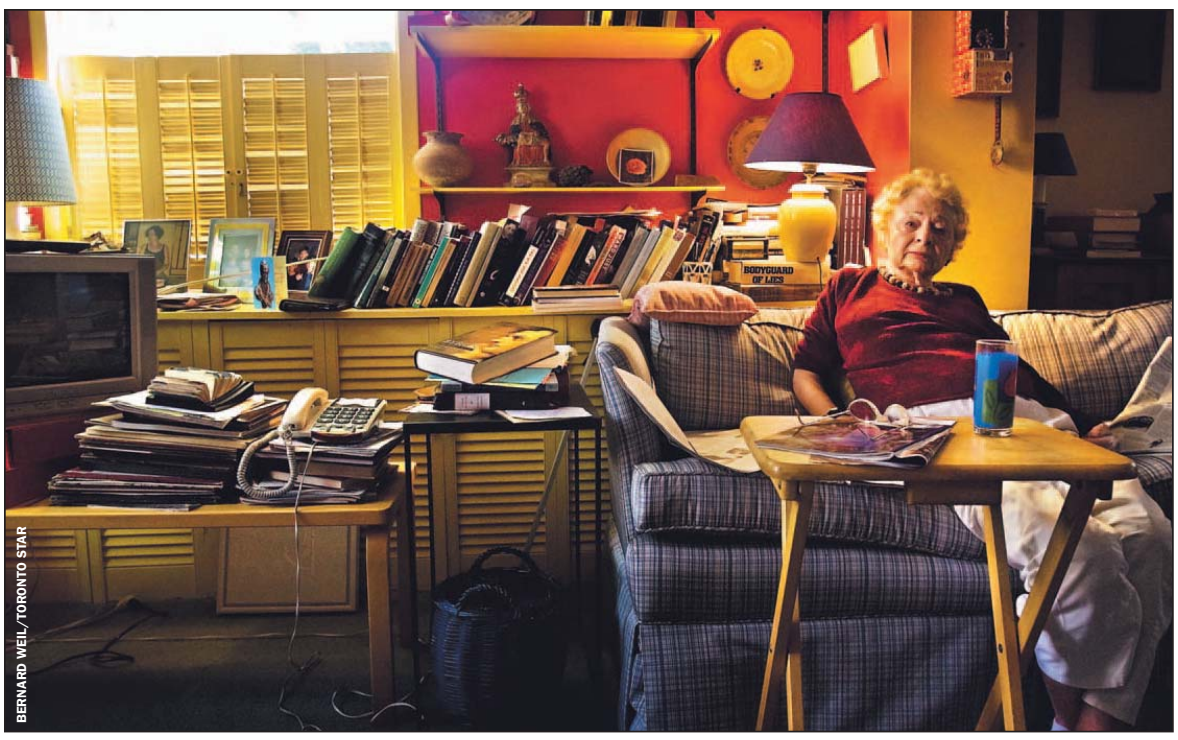
If the promise of Aging at Home is fulfilled, it will transform home care in Ontario. But as it rolls out across the province, problems are apparent.

• The CCAC system is already stretched to the limit. Each year there are 17 million personal-support and homemaking visits.

A maximum of 90 hours of home care a month is available to most people, or about 24 hours a week, on a long-term basis. For three months or less you can get 80 hours of home care a month.

For some, that isn't enough. As we become more frail, we need simple home supports - cleaning, cooking and shopping, which are proven, cost-effective ways to keep seniors independent. But once we've used up our allotment, what then? Institutionalization, at a cost of $43,000 per year?

‘No matter what, cultivate your garden’



BERNARD WEIL/TORONTO STAR

“I love this little house,” says Phyllis Grosskurth. “I tell old people: you have to pay attention to what you like, what gives you pleasure.”

I think of the hospital as the goalie of the team

HY ELIASOPH,
HEALTH ADMINISTRATOR

The lack of resources means serious mistakes are made. The *Star’s* Moira Welsh reported last October that Olivia Chow’s 83-year-old mother was “overlooked” by the CCAC for two weeks “while a surgical wound in her stomach grew raw and infected.”

The CCAC doesn’t provide enough care to keep Grosskurth at home, and if the couple couldn’t afford private support, she would have to be in a nursing home, which would mean giving up her little garden. The day will come when McMullan can no longer lift her, but he lives in a state of healthy denial, he says. “Pat and I are Siamese twins. Her paralyzed left side is the only thing that’s wrong. She’s got all her marbles. We have fun, we go out, we travel.”

• Paul Williams, a professor of health-policy management and evaluation at the University of Toronto says that while he’s “optimistic” about the evolution of LHINs and CCACs, he thinks the Aging at Home strategy is too fragmented. “We need a *system* that enables community agencies to access the full array of services seniors need.”

People in rural areas have few options in terms of aging at home, he says. And CCAC case managers have limited budgets or, in some cases, don’t have access to services people need.

• There is no formal system for sharing the innovations and “best practices” Caplan says he wants to promote.“LHINs are loaded with planners and administrators,” according to a health-policy expert, “but they don’t have enough ‘content’ people with knowledge and experience of care delivery.”

“There’s a sense that some LHIN managers are afraid to take risks,” says another health-policy expert. “Some are being cautious and just putting money into long-term care.”

• Experts note that Alberta stopped the regionalization of its health care system because of fragmentation and wildly varying services across the province.

• The lack of supportive, affordable housing for seniors is a huge problem across Canada. Out of 66,828 households on Toronto’s Housing Connections wait list, 17,126 are seniors. One-third of Toronto’s seniors are single, living below the poverty line.

Roy Romanow, head of the Royal Commission on the Future of Health Care in Canada, says the Canada Health Act should be expanded to include a national home-care program, allied with an affordable-housing strategy. “They go hand-in-glove, and they’re what the aging population needs.”

• Not everyone can stay at home, and more seniors will need long-term care as baby boomers join the ranks of the old-old. Already, elders encounter long wait lists for their top nursing-home choices and have to accept placements they don’t want.

Another weakness is the failure to strengthen crucial community agencies. “Our entire sector gets only 3 to 4 per cent of the health ministry budget, and our community agencies are hanging on by our fingertips,” says Kaarina Luoma, executive director of Mid-Toronto Community Services, which attends to people in the low-income Regent Park and Moss Park neighbourhoods. Among many other things, Mid-Toronto provides hot meals, outings and other activities that include Alzheimer’s sufferers.

Luoma laments the fact that, with hospitals and physicians getting the lion’s share of funding, community agencies “have been expected to do so much with so little, without fanfare, for so long.”

“There seems to be a disconnect between the pronouncements and the reality,” says a Mid-Toronto board member, a lawyer who asked not to be named. “If the ministry is serious about wanting to keep people at home, out of hospitals and institutions, it’s agencies like ours that are the linchpin in the strategy. The LHINs aren’t communicating well with agencies like ours.”

Spiffy offices have been set up for LHIN planners, with shiny new technology and furniture - while the threadbare community agencies stretch their dollars.

How much more money are the community service agencies going to receive? Despite repeated questioning up and down the chain, no one has an answer.

In these troubled times, there’s a danger that our sense of urgency over the aging population will be dampened by economic realities. Several weeks ago, Ontario Finance Minister Dwight Duncan announced that the global economic slowdown - recession? depression? - meant the decline of government revenues and the ballooning of a $500-million deficit that, no surprise, will result in reduced funding for many programs, including delays in hiring 9,000 nurses and setting up of family-health teams.

However government sources insist that Aging at Home remains a priority. In fact, if the promise of the initiative is fulfilled, Ontario could be one of the best places in the world to grow old.

That’s a big if. It’s up to citizens, now, to make sure it stays on course.

“The big thing I haven’t said is that I’m not writing anymore,” Grosskurth says. “People tell me, ‘You must be writing, ‘ but it’s so embarrassing. I can’t. I don’t have the energy. All the starch seems to have been knocked out of me.”

Still, she seems happy. “I love this little house,” she says, smiling at her husband. “I have a loving family and lots of friends. The companionship of Bob... I couldn’t do it without him.

“I tell old people: you have to pay attention to what you like, what gives you pleasure. I love clothes. I love food. I still cut out recipes even though I can’t cook any more. I love to read. If you love reading, you’ve got it for life. I’m grateful to my friends and my children. I know there are grand gardens around the city but I couldn’t be happier with my little garden.”
“No matter what,” and here Grosskurth leans forward for emphasis, eyes sparkling: “Cultivate your garden.”

A compendium of hope

PERSONAL JOURNEY:
To understand what’s worth imitating in senior care, Judy Steed surveyed dozens of initiatives. She found programs that work for veterans, for Chinese elders and how to use your Palm Pilot when your memory starts to fail. The future? Think local.

Elizabeth Dingman has had her share of falls — one, when she “went down like a tree in a forest” — but she has now graduated from the school of falling.

Literally.

An innovative program at Toronto Western Hospital teaches seniors how to dodge fall-inducing risks, as well as preventative exercises and nutrition so they’ll have a fighting chance against the next spot of black ice.

“You’ve no idea how hard you can land, or how much you can hurt yourself, when you get old,” says Dingman. (“I’m as proud to say I’m 90 and a half as I was to say six and a half.”)

After a few nasty falls, Dingman signed up for the three-month Falls Prevention Program. It begins with an assessment by a geriatrician. A physiotherapist tests balance and mobility. An occupational therapist goes over activities of daily living. A pharmacist reviews medications. The full team develops a comprehensive picture of the individual’s situation and recommends any necessary improvements to diet, exercise, or medical care.

Then the work really begins.

Today, the elderly participants are seated in chairs, exercising; they reach for the ceiling, then lift their feet, tap their toes, lift their legs, bicycle their arms —“like swimming,” says one elderly lady, “I used to love to swim.”

Another, 85, doesn’t want to lift her legs. Her daughter says: “My mother used to be so strong. You should have seen her.” Responds her mother: “That was a longtime ago.”

After the fall can be the most dangerous time. Geriatric nurse specialist Carol Banez, who leads the program at Toronto Western, says fear of falling can become so extreme that seniors are “paralyzed by fear,” leading to decreased physical activity, impaired functioning, isolation, shame, stress, negative thinking and depression.

“They’ve fallen and they’re afraid of falling,” Banez says, “so they don’t go out. It’s a downward spiral that can be deadly. We try to help them break out of it.”

Falls among seniors are already one of Ontario’s most critical in-jury problems. A fall can mean the end of a life of independence— 40 per cent of nursing home admissions are the result of falls— but the resulting hip fractures are deadly: 20 per cent of those 65 and older die within a year of fracturing a hip.

A recent article in the *American Geriatrics Society Journal* shows the Toronto Western Hospital program increases strength, with 82 per cent of participants reporting improved balance and confidence. “In the year before referral, 41 patients reported experiencing falls,” the article states. “During the 12-week program, 21 falls occurred in 39 patients,” with no significant injuries. (Other studies show that one in three seniors living at home will fall at least once a year; 50 per cent of the falls will result in significant injury.)

Thanks to the exercises in the falls program, Dingman’s strength improved, and she learned to focus on her physical actions. “I’ve learned to go at my own pace and be at ease,” she says. “I don’t dare get all in a panic — when you get agitated, that’s when accidents happen.”

She no longer multi-tasks, she is careful when reaching for things, and she concentrates. She’s also given up swivelling.

“They taught us not to use swivel chairs on wheels,” Dingman says. “Once, I was swivelling and leaned down to pick up something and fell.” The worst fall occurred one Saturday when she’d sat down in the morning to read the paper and didn’t get up again until 3 p.m. “I’d sat too long —and went down like a tree in the forest.”

Programs we love


BERNARD WEIL/TORONTO STAR

Eighty-one-year-old Florence Hacker graduates from the Falls Prevention Program at Toronto Western Hospital.

The future of care: small-scale, attentive, local

Small mercies

The gold standard for home care in Canada, experts agree, is a program that started in 1915.

VIP — Veterans Independence Program — targets aging soldiers who served overseas, or their widows, and provides them with small services to help them stay independent.

Veterans Affairs' annual budget is $2.9 billion; $303 million of that goes to VIP. There are197,460 war service veterans; their average age is 84, and 102,164 of them receive VIP services. Only 4,190 occupy nursing home beds.

The average cost per person for VIP home care is about $2,680 a year, compared with $43,000 for a room in an Ontario nursing home or up to $1,000 a day in hospital.

Bruce Harsell, 84, is the treasurer and bar manager at the Royal Canadian Legion, branch 11 in East Toronto and the perfect model of the independent senior. "I can manage fine," he says, "with the help of VIP. I have everything I need."

Harsell served overseas in the RCAF, worked for the same company for 48 years, and for half a century has lived in the Toronto house he bought with his wife Marion, where they raised two sons.

Marion died in 2003, but just before her death, VIP contacted Harsell. "They told me they could help me manage things

Housekeeping help can keep a veteran at home

at home and came down to see what I needed. They put me on housekeeping and outside maintenance... If you need more, you just phone them. They're easy to talk to. It's not like you're fighting for it."

At Harsell's cozy little house, the grass is cut, the leaves raked. Inside, family photographs and mementoes are nicely arranged in the living room and he proudly shows off a spotless kitchen.

The VIP model shows that when seniors are supported in small ways, they age with a greater sense of well-being, which translates into better individual health and lower costs to the system.

"It makes me feel good," Harsell agrees. "I own my house. I pay the taxes. I'm not going to be hustled off to a nursing home because I can't cut the grass or do the vacuuming.

VIP focuses on what Ontario's Community Care Access system does not. "In Ontario, if you just need a little help with house cleaning, you won't be eligible for CCAC home care," says Margaret MacAdam, a Toronto gerontologist. "In Ontario, you have to need help bathing to get CCAC services. They're targeting a more needy population."

In fact, home care provided by the Ontario government's community care program is limited to providing *medically necessary* services to maintain seniors at home. That, says B.C. health policy analyst Marcus Hollander, means Ontario is ignoring the critically important role of non-medical services.

"If the VIP services keep people out of facilities," he says, "they are medically necessary." Hollander led a research team that compared the costs and outcomes of VIP home care versus long-term care and supportive housing. The team interviewed veterans, widows and caregivers across the country.

One of the findings was that wait lists for nursing homes shrank when veterans joined VIP. Once they could manage at home, with support, they no longer wanted to get into a nursing home.

"We showed that clients — and taxpayers — get better value for money when you substitute home care for facility care," says Hollander.

But MacAdam notes that the bedrock of home support is still the family.

"None of the public programs replaces family contributions. If there's a breakdown, you call your daughter. She may not live in your city but you'll count on her to take action. If you're on your own, you have to count on the reliability of the service."


BERNARD WEIL/TORONTO STAR

Veteran Bruce Harsell gets the services he needs, when he needs them: "It's not like you're fighting for it."

A masterpiece

Heaven on earth for seniors can be found on The Esplanade in downtown Toronto, a few blocks from the St. Lawrence Market. PAL Place, formally known as the Performing Arts Lodge, is an attractive brick building of 205 apartments currently housing about 230 residents, most of them older people who have worked in the performing arts. A history of employment in the sector, where many residents are still active, is a requirement for admission.

About two-thirds have rent geared to income subsidized by the City of Toronto; the rest pay market value of roughly $860 a month for a one bedroom apartment. But in addition to affordable housing, PAL also provides a real community for older people, replete with a buddy system and a group of volunteers called "supporting cast."

"If people don't see me for a day, they'll call, they'll knock, they'll break the door down if they have to," says Mary Jolliffe, 84, who worked in communications for the Stratford Festival, the National Ballet of Canada and the National Arts Centre. She moved in 1994, a year after the building opened. "My neighbour is nosy as all get out, thank goodness."

Residents can also get support from Dixon Hall's Supportive Housing Project, funded by the Ministry of Health. Dixon Hall staff offer personal care such as assistance with bathing and dressing, as well as light housework, laundry, grocery shopping and meal preparation.

Studies show that such supports are the most essential items in helping elders maintain their independence and stay out of institutions. Which saves the system a lot of money in the long run.

This is a building where people can gather in the Friday night pub, called The Celebrity Club, or in the Crest Theatre Green Room, which has morning "Kaffeklatsches,"

a stage and a piano, and hosts musical performances and art shows. There are exercise classes in the dance studio. Residents have their own plot on the rooftop garden, where they can barbecue and sit at night to watch the stars. The library specializes in theatrical books and has more than 1,000 published plays, plus piles of paperbacks and DVDs.

Librarian Audrey Hozack, 88 — formerly assistant warden at Hart House and a Royal Ontario Museum employee (she still works at the Textile Museum) — moved here in July 2000, four years after having a stroke. The camaraderie of PAL, she says, stands in stark contrast to her previous life in the apartment building where she had her stroke. "The only person I knew was the superintendent. You're isolated in buildings like that. Here, you feel like you're part of a community, and as you get older, that's very important."

She enjoys the mix of ages. "The first generation of residents was older," and as they die off, a younger group in the performing arts is moving in, which she thinks is good for "a sense of optimism. Lately, most of the parties are 'in memory of . . .' We had the 92-year-old (former) Rockette who died last week."

Hozack also observes that the building's location adds much to its appeal. "You have no idea how great it is to step across the street to the St. Lawrence market," she says. "At 4 p.m. on Saturday when they reduce the prices, we all rush over."

PAL also a similar building in Vancouver, and there are plans to develop PAL residences in several other Canadian cities.

BERNARD WEIL/TORONTO STAR

Judith Glasner, 72 performs tests during her final assessment in the Falls Prevention Program.

VINCE TALOTTA/TORONTO STAR

Don Owen, 77, paints in the lodge's studio, surrounded by his works. A film director, Owen is known for movies like *Nobody Waved Goodbye*.

VINCE TALOTTA/TORONTO STAR

Victoria Mitchell serves coffee to fellow residents. Before moving in, Mitchell was an actor, agent and casting agent. She's 76.

A UNIQUE CO-OP

The OWN Housing Co-op, built by the Older Women's Network, was the last co-operative housing project to be constructed before the Mike Harris Conservatives eliminated Ontario's affordable-housing programs. It opened in 1997, with 70 per cent of residents in the 142 units paying rent-geared-to-income, and the remainder paying market value.

"We just got in under the wire," say Erin Harris, a retired nurse and activist with OWN.

"The basic problem for women, globally, is poverty, especially for older women," she continues. "If they married the wrong guy and ended up divorced, if they didn't get the good jobs, if they don't have a company pension — and most women don't — they're going to be poor in old age.

"The number one goal of the Older Women's Network, as a political action committee, is to try to improve pensions in Canada. Their second goal is to get home care mandated across the country as part of the Canada Health Act and medicare.

Next, OWN would like to see action on affordable housing, along the lines of the OWN Co-op. Al-though the co-op has changed over the years — "we have a mixed population now, with more families," says housing manager Esther Ford — older women are still the majority.

Ethel Meade moved in before OWN officially opened, 11 years ago. As she approaches her 90th birth-day, she's still delighted to be there. The rent-geared-to-income aspect has been tremendously important, she says, "especially in my generation, when most women didn't have careers. The only thing they had was their husband's pension."

Ethel was widowed at the age of 45, with three daughters to raise, and went back to school. Eventually she got her Ph.D. and taught English literature at Ryerson, "but it was a late career."

Now, with seven grandchildren and two great-grandchildren, she laughingly refers to herself as "a matriarch. It's fine. I love my life, I sure do."

Much of her contentment comes from OWN and Dixon Hall's Supportive Housing Program. "I had an emergency once and they came to my rescue. I woke up with a knee I couldn't put any weight on. I phoned them, they arrived in half an hour with a wheelchair, they took me to a clinic, took me to a hospital for an X-ray, and loaned me a walker."

She proudly maintains her independence, and says she goes out "more and more without my walker. The main point is peace of mind —to know that if you need help, you'll get it."

Extended family

Back in the 1980s, Dr. Joseph Wong became troubled by the fact that many frail Chinese seniors were ailing in isolation, in need of care and connection, and often stymied by a language barrier.

Wong was then a family physician with an office in downtown Toronto's Village by the Grange, near Chinatown. After years of planning with a group of Chinese-Canadian friends, in 1994 the immigrant from Hong Kong unveiled the non-profit Chinese Community Nursing Home for Greater Toronto. The 94-bed institution, on McNicoll Ave. in Scarborough, opened with Florence Wong (no relation to Dr. Wong), as executive director. Since then, she and Dr. Wong have fuelled the growth of its rapidly expanding empire, now called the Yee Hong Centre for Geriatric Care. In Cantonese, "Yee Hong" means good health in a holistic sense, replete with happiness and contentment.

Yee Hong has 805 long-term care beds in four locations (two in Scarborough, one in Markham and one in Mississauga) and offers services for South Asians, as well as Filipino and Japanese seniors. The Yee Hong network also includes two seniors residences with a total of almost 500 units, housing 800 people, plus many community-based programs serving more than 15,000 seniors.

The day program is particularly popular among Chinese seniors. Dr. Wong's dream of enabling Chinese elders to age in settings that reflect their cultural values — and provide them with meals, activities and languages they understand —has been realized. And on a tour of Yee Hong, watching elderly people dance, listen to music and do Tai Chi, it's easy to see that the participants are fully engaged and very comfortable.

"We know how hard it is for seniors to navigate the health care system," Florence Wong says, "especially when you're an immigrant and have language difficulties. Here, there are no communication barriers; whenever someone needs help, they get it in their own language."

The dream: Allow seniors to age in settings that reflect their values

Yee Hong has a waiting list of 2,200 people for its nursing homes; it takes five to six years to get in, even if you're willing to pay for a private room. In part, the waiting list is so long because Yee Hong delivers such excellent care. "People live on average for 2.7 years in nursing homes," Wong says. "At Yee Hong, they live on average for seven years."

She's also very proud of her bed-sore stats: "Industry-wide, 30 percent of seniors have bedsores. They can get infected and cause death. At Yee Hong, only 3 per cent get bedsores."

There is, however, one problem that Yee Hong shares with its sector: labour shortages. Yee Hong has 970 workers. While most nursing homes are unionized, Yee Hong is not. "The 24-hour operation of most facilities is not attractive to young people, who don't like the idea of shift work and are not prepared to work as hard in as difficult conditions as their parents' generation," Wong says.

Yee Hong's labour problem is exacerbated by the need for Chinese-speaking staff, including nurses. Across the system, a generation of older nurses is getting ready to retire, and the younger generation appears to be avoiding nursing.

While most Yee Hong residents speak Cantonese, most immigrants from China nowadays speak Mandarin, and most new hires at Yee Hong are Mandarin speakers.

Another challenge is teaching staff to deal with sensitive situations. Old people are not all sweet angels, especially when they suffer from dementia and they get frustrated. "They can act out," Wong says, "but we don't want to drug them unnecessarily."

Wong says Yee Hong is "very pro-active in educating staff about dementia, to avoid provoking or irritating residents. Don't approach them from behind, don't startle them.

If they're in a bad mood, don't push the issue; come back later. People can be unpredictable, especially when you're giving them personal care, bathing and dressing them.

"If they are agitated, they can be taken to various calming environments, including a "snoezelen room," where they're exposed to lighting effects, sound, music and other sensory stimuli with a soothing effect. "Just a quiet moment, to hold hands," says Wong. "I'm so touched by the way staff hold the hands of seniors.

Yee Hong has been approached to work on projects for seniors in Beijing and Shanghai. Wong says the situation in China for elderly people is difficult. "In rural areas, people are still very poor. The younger generation move away from the villages to work in the cities, leaving the old people behind with children.

In Hong Kong, she says, middle class families may send their elders to mainland China to be looked after there, because wages are lower. But the elders often feel isolated; they've lost touch with their mainland China roots and often don't know anyone in the community they've been sent to.

Funding for Yee Hong's facilities and programs comes from Yee Hong Community Wellness Foundation, which is chaired by Dr. Wong, now 60, who still practises medicine in the Village by the Grange neighbourhood. The main fundraiser mounted by the foundation, which also takes care of communitarians for the Yee Hong Geriatric Centre, is the annual Dragon Ball.

STEVE RUSSELL/TORONTO STAR

Chinese seniors participate in morning exercises at the Yee Hong Centre for Geriatric Care in Toronto, which has 805 long-term-care beds spread across four locations.

TAKING CHARGE

"Care of seniors is a community responsibility," says Larry Chambers, chief scientist and CEO of Ottawa's Elisabeth Bruyere Research Institute, recognized for its leadership in developing innovations for seniors. "We have to empower people to be resourceful."

And so, Chambers and his team dreamt up CHAP, short for the Cardiovascular Health Awareness Program.

Chambers' team travelled to 39 Ontario communities - from Kenora to Cornwall - and trained up to 60 seniors in each community to help other seniors take their own blood pressure and assess their own cardiovascular profile.

High blood pressure is the number one modifiable risk factor for heart attacks and strokes, and also has an impact on diabetes and even dementia. Some studies have shown that almost half those with high blood pressure don't know it.

CHAP is run out of local community agencies; volunteers are educated about risk factors for chronic disease, the impact of smoking and alcohol, and taught about the value of exercise and a healthy diet - information they pass on to their fellow seniors.

"When one of our volunteers spots someone with high blood pressure, the information is sent back to the person's family doctor and action is taken. We call that 'closing the loop,'" Chambers says.

CHAP has 16,000 participants and reaches 25 per cent of the senior population in each of its communities. "We aim to show that CHAP is reducing heart attacks, strokes, hospitalization and death. We have evidence that it reduces blood pressure and people's health behaviour has improved."

The Ontario Ministry of Health Promotion has just renewed the program for two more years.

"The point is that chronic disease is a life sentence," Chambers says. "If you've got diabetes or heart disease, you have to live with it, and the system has to figure out how to help you manage it."

KNOWLEDGE BROKERS

Knowledge transfer is the trendy buzzword in senior care, and nowhere is it better illustrated than the Seniors Health Research Transfer Network.

SHRTN for short – what's a program without a nifty acronym? – is essentially a province-wide system of trading tricks. It links caregivers in 622 long-term care facilities serving 85,000 residents and employing 100,000 people.

Here's an example of how it works:

Incontinence is one of the main reasons seniors end up in long-term care; it afflicts up to 85 per cent of the residents of nursing homes. Those most likely to develop incontinence also have mobility or cognitive impairment. It's a difficult management issue for nursing staff. It's embarrassing and humiliating for elders, and contributes to isolation and depression.

It's called SHRTN for short — after all, what's a program without a nifty acronym?

In 2006, recognizing the need to share best practices on incontinence care, SHRTN facilitated a province-wide discussion.

What resulted was widespread improvement in the way the problem is treated.

So significant were the updated protocols that "some residents are already regaining continence," says Micheline Seguin, a manager at Carlingview Manor in Ottawa. (Reducing urinary tract infections and reducing the cost of supplies such as diapers helps seniors and also reduces staff time.)

"SHRTN is cutting-edge, it's trail-blazing, it's doing ground-breaking work in applying the concepts of knowledge exchange and increasing capacity," says Megan Harris, 28, a SHRTN knowledge broker who works out of a home office in Milton.

SHRTN has 19 themed groups that meet – usually online – to discuss everything from Alzheimer practices and osteoporosis to diabetes and the flu vaccine.

If you're paid to care for seniors, if you're a researcher or policy-maker, you can contact SHRTN (shrtn.on.ca) and reach a knowledge broker who will guide you to the appropriate "community of practice, " such as Activity and Aging or the Alzheimer's Knowledge Exchange, which will in turn give you access to innovations and best practices.

SHRTN is the brainchild of Larry Chambers, chief scientist of Ottawa's Elisabeth Bruyere Research Institute, which is distinguished, like Toronto's Baycrest, for its leadership in developing innovations to improve the lives - and the care - of elders.

Policy makers call SHRTN to find out about the latest hot topics. A recent example: developmental disabilities and dementia. Harris hosted "a fireside chat" - an online conference - on the topic of dealing with older adults who have Down's Syndrome, have outlived the prognosis for early mortality, and now have dementia plus chronic disease - "all of which makes their care more complex."

SURROGATE MEMORY

What time is my dentist appointment? Your dentist appointment is 1 p.m. tomorrow.

For seniors with severe memory impairment - often related to aneurysms, strokes, tumours or brain injuries - the only way to answer the first sentence is to program a Palm Pilot to prompt the correct response.

"The future (for seniors) is not about pouring money into big institutions," says Brian Richards, a psychologist at Baycrest, a Toronto geriatric centre. "It's about teaching people skills so they can continue to live at home."

Richards' breakthrough program, Memory Link, does just that.

"You can't function independently if you don't know what you're going to do next," Richards says. "We all have normal memory failure from time to time, we forget to pick up the laundry, but my clients in the Memory Link program never know what they're supposed to do next."

Sidney Cohen, a 75-year-old former publisher who has mild cognitive impairment, demonstrates. Cohen's Palm Pilot is loaded with a computerized day-timer that includes his wife's schedule; she's active in Holocaust education and he needs to know where she is.

"I can pick any day this year, and I know what's scheduled," he says. "I know where I have to be. At 1 p.m., I get a beep. It says, 'Leave for Baycrest.' At 2 p.m., it beeps. 'Be at Baycrest.'"

The technology does what the mind can no longer do. Developed at Baycrest and funded by OHIP, charitable foundations and hardware donations from palmOne Inc., the program is based on research that showed different systems of memory can compensate for each other when one system is impaired.

"It's learning without awareness," Richards says. "Over six to 12 weeks, clients can acquire the skill set to use the Palm Pilot reliably without any memory of how they acquired the skills."

Clients are drilled by trainers, including volunteers, until they acquire the habit - the procedural memory - of using a Palm Pilot programmed to tell them where they are, why they are there and what they are supposed to be doing. The trick is, no errors are allowed.

"Trial and error doesn't work when you can't remember your errors," Richards says.

"Once they've got it, they've got it. Like riding a bike."

"Now," Richards says, "all we need to do is roll out Memory Link across the country."

A STORM SHELTER

The old house on Carleton St. may have been charming in its day, but it's undeniably shabby now. Still, it houses a miracle-maker in Ontario's Aging at Home strategy.

Mid-Toronto Community Services offers programs and support to elders, people suffering from Alzheimer's or HIV-AIDS and adults with disabilities in the Regent Park, Moss Park and adjacent east downtown neighbourhoods.

If the demographic tsunami is ever to be contained, it will be on the front lines at agencies like Mid-Toronto, which exist in most communities across the province. They're threadbare, they stretch dollars out to the horizon, and they actually care about the people — often poor people — they serve.

I spend a few days seeing how the program works. We're in a drafty parish hall attached to St. Peter's Church, where Mid-Toronto leases space. A dozen seniors of all sizes and ethnicities are seated around a table, attending the members' council meeting. The membership fee is $21 for the year; some people pay $5 every three months, and others can't afford the fee. Mid-Toronto encompasses one of the richest postal codes in Canada, Rosedale, and one of the poorest, Regent Park. Rosedale people rarely venture here, and if they do, it's as volunteers and fundraisers.

When people sign up, Laura Stanich, the co-ordinator of the adult-enrichment program for people 55 and over, completes an intake form for each individual to help her understand the conditions of their lives. Prevention starts here.

Most members live alone on very limited incomes. In the city of Toronto, there are 338,000 seniors(14 per cent of the population and the fastest-growing segment); about 40 per cent are single, with median incomes of $17,700. From 1995 to 2000, the number of low-income seniors almost doubled. Indeed, statistics show that the rich are getting richer, and the poor, poorer.

Mid-Toronto's seniors are often quite isolated before they connect with the agency — usually through a neighbour who attends— and often it becomes the main focus of their lives. "People often isolate themselves in depression, illness, shame, as they age," says Kaarina Luoma, Mid-Toronto's executive director. By attending Mid-Toronto, "they become part of our family. The social contact breaks through the depression and anger; they find hope and regeneration."

They can receive a call every day, to remind them of activities they're interested in, to make sure they're doing well. "If they don't answer, I might pop in for a home visit or send a social worker or building manager," Stanich says.

Mid-Toronto helps clients get rid of the bedbugs that bedevil many of the buildings where they live. If Stanich notices developing problems — a limp, cognitive decline, malnutrition — she can take preventive action. She refers some clients to the adult day program for people with Alzheimer's.

Malnutrition — the "toast and tea syndrome" — affects many seniors. Here again, Mid-Toronto helps by picking up clients in a van in the morning and bringing them in for activities and lunch, a "real meal with meat, veggies, potatoes, juice and dessert," Stanich says.

Facilitating the members' meeting, Stanich engages her "regulars" in lively discussion about the activities they enjoy. "This is your program," declares the warm, friendly 26-year-old. There's a loud consensus: bingo. They want lots of bingo. They want bowling and line dancing. They want to try a Greek restaurant and a Pakistani restaurant.

Syed, 66, is from Pakistan. "These people give me love and affection," he says, smiling. "I'm very happy here. We are friends. I thank Canada for its multiculturalism. My wife is my opposite. She wants to stay at home and pray five times a day and recite the Koran."

Lila, 78, says she'd been depressed, living alone, having lost her mother, her brother and her boyfriend all in one year. "It's hard when you're old and can't go out at night because you're afraid of the drug dealers." A counsellor recommended Mid-Toronto. "I joined this group. It lifted me up."

HOME, NOT ALONE

"We try to tell the government how much we save them," says Norman Shao, manager of Dixon Hall's Supportive Housing Project for Seniors.

The program, which helps some elderly Torontonians to continue living in their own apartments, is an excellent example of how to deliver home care that's cost-effective, flexible and sensitive to people's needs. It serves seniors in four buildings in the St. Lawrence Market area, including the Older Women's Network Co-op and PAL Place.

But Shao, who has run the program from the outset, says it can't keep up with demand. "We're stretched to capacity. We are here 24/7, with three shifts going for 10 years."

Dixon Hall is an exemplary multi-service community agency - one of the places that tends to be invisible while being essential to maintaining the social fabric through its seniors' day programs, its music school and its activities for disadvantaged youth and homeless people.

Shao's program is headquartered in one of the four apartment buildings it serves - Old York Tower on The Esplanade, where about 85 per cent of the residents are elderly women occupying rent-geared-to-income apartments subsidized by City of Toronto social housing. The waiting period to get in is up to 10 years. "The residents say they feel like they've won the lottery," Shao says, and indeed they have.

Because Dixon Hall's office is on the ground floor of Old York Tower, the eight full time and 10 part time workers get to know their clients well. Currently, they help 100 people maintain their independence; about 20 per cent have dementia.

"There is a pull cord in every apartment," says Shao. "If someone has an emergency, they pull and staff responds." If someone falls, "all they need is a little help to get up. We can do that. Without us, it's a 911 call, ambulance, go to hospital."

This is the kind of home care most of us will need, if we live long enough. As Stana Pascu, the Supportive Housing Project's care coordinator, says, "We're looking after people who just need a little bit of help to remain independent. They're not ready for a nursing home." But they would be without Dixon Hall.

Adds Shao: "They feel secure, knowing we are here. You know what they fear most? The loneliness. Being alone, dying alone, afraid no one will find them. They keep telling us that."

Suddenly, my life changed

Reporter Judy Steed plays with her dog, Celeste, on the dock of her cottage this past July.

PERSONAL JOURNEY

Judy Steed is a healthy woman. She practises yoga. She eats well. She doesn't smoke. But one day last year, her eyesight began to blur. Before she knew it, she had been diagnosed with an aneurysm that could burst at any time. Here, she tells her story

This time last year, I was in Victoria, just starting my research on aging. Victoria was the ideal takeoff point, I'd thought, because it's already the mecca for seniors in Canada. I wanted to get a feel for what society is like when it's overtaken by "them"— a lot of old people.

I didn't know it yet, but I was holding myself aloof from my subject. As far as I was concerned, aging happened to other people. I am fit, I quit smoking in my early 40s, I've done yoga for 30 years, I teach a fitness class at the Metro Central YMCA. I drink green tea with chopped fresh ginger and I commuted by bike until the end of my formal working life. I didn't know it, and I wasn't ready for it, but I was about to be introduced to my own mortality.

In Victoria, I did a lot of walking from interview to interview, so I could enjoy the sea air and the beautiful plants and trees in the lush gardens of the city. As I walked, I noticed the vision in my right eye was slightly blurred. I thought my glasses were dirty, and cleaned them every day. My eyesight was still blurred. Hmm, maybe I'm developing a cataract, I thought — a natural clouding of the eye's lens that occurs in most people over the age of 65. I hadn't hit that land-mark, yet — I was only 64 — but I was in the territory where things start to happen.

Back in Toronto, my optometrist tested my eyes and told me there was nothing wrong with them —from the front. He suggested something might be pressing on the back of my right eye, perhaps on the optic nerve. Indeed, I was starting to feel the buildup of pressure.

I was sent to an ophthalmologist — yes, the waiting room was packed with old people — and an MRI was booked for the following month. Over the weekend, the pressure on my right eye intensified. On Monday, just before noon, I rode my bike to the emergency department of Toronto Western Hospital, which has one of the best neuroscience centres in North America, a friend had told me; they would know what to do with me.

I worried I would be overlooked simply because I was a woman over the age of 50. Now that I was researching aging, I knew older women are often neglected by the health care system.

As I waited in the emergency department at Western, I saw old people lying on gurneys in the corridors, for hours. I heard doctors ask, in muted tones, what medications old people were on, and listened in astonishment as elders listed dozens of prescription drugs they were taking.

Eventually, an intern examined my eyes and told me I would probably be sent home to await the MRI ordered by the ophthalmologist. Suddenly, I was very worried.

By a stroke of luck, the doctor in charge decided my symptoms warranted a CT scan. At 6 p.m., I was scanned and told to wait. Finally — it was dark by now — the neurological resident sat me down. He looked grave. "You have an aneurysm behind your right eye," he said, "a giant aneurysm."

A follow-up CT angiogram was conducted, with dye injected into my body, showing the aneurysm in greater detail. Most aneurysms are like little blueberries; mine was the size of a couple of cherry tomatoes, but distorted, wrinkled and crushed together.

At midnight, I was formally admitted, taken to a room and kept there for four nights. (My husband picked up my bike the next day.)

I didn't know anything about aneurysms, except that they were balloon-like bulges in an artery that could potentially burst, which is how most people discover they have one. I didn't know one-third of people with aneurysms die before receiving treatment, one-third die during the hospitalization-surgical process and one-third emerge in good condition.

All I knew was that the doctors didn't know what had caused mine, how long it had been there or what could set it off. Was there anything I should not do, as I awaited surgery? Nope, I was told, there was no way to predict. I could be sitting in a chair reading a boring book and the aneurysm could burst — or not.

On my second night in hospital, I was awakened by a bed being wheeled into the room, on the other side of the curtain divider. The newcomer/patient yelped in distress and moaned intermittently for the rest of the night. I slept fitfully, only to be awakened early in the morning by a man darting back and forth.

"Look at me, Mom. Open your eyes. Are you in pain? Where's the pain?" He rushed out to find a nurse, rushed back to his mother and out again, trying to get her the help she needed.

I peered around the curtain at my new neighbour. Scrunched under the covers was an old woman, eyes shut tight, face wrinkled like an apple doll.

John Jacobi introduced himself and his mother, Ruth. He stroked her forehead. He spoke to her kindly. Though her eyes remained closed, her son's tenderness calmed her.

"You're so kind to her," I marvelled.

"Oh, she was always my champion," Jacobi said, holding his mother's hand. "You should have seen her when she was younger. My mom was a go-getter. She came to Canada all by herself, from Switzerland, in 1955. She had beautiful red hair and she worked as a hairdresser at Elizabeth Arden." His mother's eyes peeked open. A small smile played on her lips.

"You have no idea what old people go through," he said. "I've been in six different hospitals and five different nursing homes with my parents."

The pressures of "the system," he said — constant demand, lack of space, tight budgets, staff shortages—exhaust workers dealing with chronically ill elders, like his mother.

WHEN I WAS discharged from the hospital, I was given a tentative date for surgery. One of the neurosurgeons, Dr. Mike Tymianski, described the procedure. The only thing I really heard was at the end, when he said there are always risks with any surgery and the risks in this case could be blindness or death.

I had my surgery on Dec. 14. When I clambered onto the operating table, in the chilly air-conditioned theatre, surrounded by high-tech machines and professionals — at least 10 — in blue hospital surgical garb, I felt as if I were in a movie.

I wasn't scared. Maybe I was numb. The professionals were brisk and moved with precision. Dr. Chris Wallace, the chief of neurosurgery, was there, as was Tymianski. Two of the top neurosurgeons, for my procedure. That's good.

Nurses covered me with a warm blanket, spoke softly, held my hand, and I lost consciousness. The surgery, scheduled to last four hours, extended to eight.

When it was over and I was

It's a miracle so many of us survive

wheeled out of the operating room, my family was waiting but I wasn't aware of them; my husband, Lankai, daughter Emily, and her best friend Nadine, were shocked by the sight of my blood splattered all over the walls of the operating room.

I came to, in my hospital bed, my head like a block of pounding concrete swathed in a thick white bandage. Through the fog, I was relieved to hear the voices of Lankai, Emily and Nadine.

My head hurt. I welcomed the morphine I was offered, though it made me groggy. Desperately thirsty, I sipped cranberry juice in crushed ice and threw up.

When I finally got the energy to get out of bed and the courage to look at myself in the bathroom mirror, I saw Frankenstein looking back. I had an incision in my neck; the surgeons had to slash the area where my carotid artery descended through my neck, in order to stop the blood flow while they clipped off the aneurysm.

There had been complications. These surgeries are high risk; it's a miracle so many of us survive.

I had to watch my step. Hold on to things. Sleep a lot

Before I was discharged three days later, the bandages came off, enabling me to see the jagged incision, held together by metal staples, that zigzagged across my head and around to my right ear —where the surgeons had sawed through my skull to get in behind my right eye.

At home, I felt "old." Not just slowed down. I had to "watch my step," hold on to things, sleep a lot. I had scoffed when my husband had installed a handrail going up the stairs in our narrow Victorian house, but I needed it. I used it.

I could not do yoga, let alone lead a class. I didn't have the strength to lift my five-pound weights. I feared my muscles would turn to flab. I feared I would never recover my energy, that I would be the first person in the history of the Atkinson Fellowship who would be unable to complete the assignment.

Recovering from the craniotomy, I was afflicted with an exhaustion I'd never known. All I could do was get up, watch TV, then go back to bed. I thought of all the people I'd seen in nursing homes. Now I knew what it was like to have sunk into a place of fatigue and lack of interest. It was hard work to pay attention to other people. It required thinking.

For a few weeks, I felt dizzy, seasick, reeling from side to side in rough seas. I couldn't face going out. We tried a trip to the cottage and, though I kept my eyes closed in the car — driving made me dizzy —when we got there, the world swirled and I couldn't bear walking.

I told my friends Helen and Tom Morley. She's 90, he's 88; they're both doctors.

"That's what we feel like most of the time," Helen joked.

Tom laughed. "We totter around. Because of old age. In your case," he said — he had been chief of neurosurgery at Toronto General Hospital and knew what he was talking about — "you'll recover."

Imagine that. I would recover —and I did.

But Ruth Jacobi, who shared my hospital room at Toronto Western, cannot "recover." Her condition is old age.

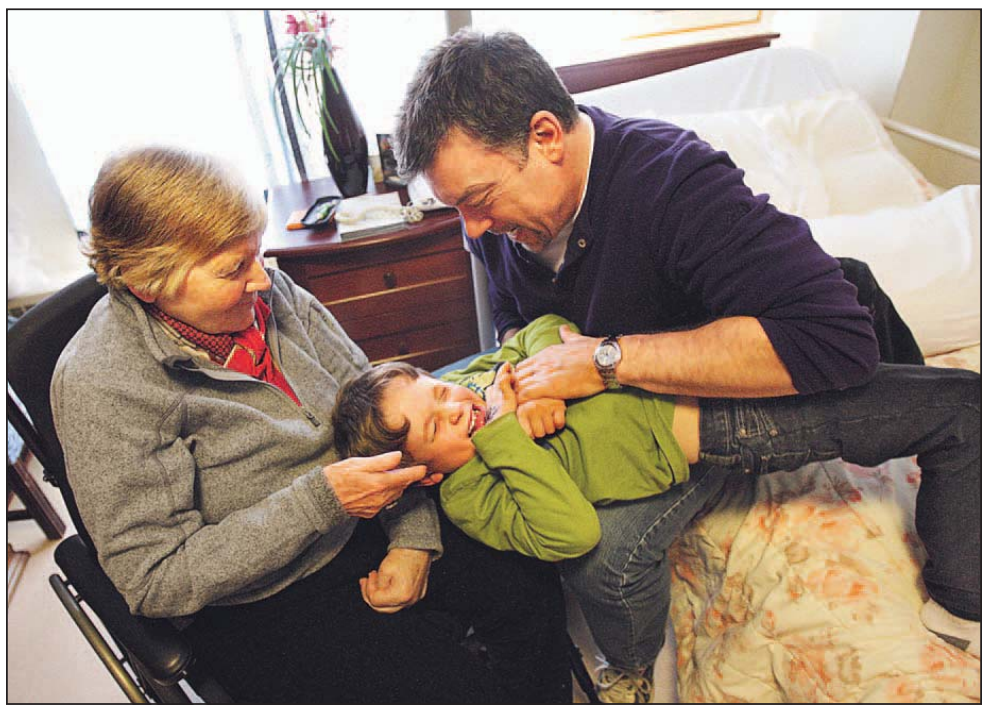
I was haunted by the image of her son running back and forth in the hospital, talking to doctors and nurses, sitting beside his mother, who was so utterly vulnerable, and he so loving and caring.

I felt such gratitude for my own loving family and friends and for the society in which we live, for the Ontario we — the collective we, going back generations — have created, the universal health-care system we've developed and now the Aging at Home initiative that will help us grow old where we want to be — in the community, where we have a life. The gift of the aneurysm is that it took me to a place of utter vulnerability and allowed me to experience the best of a life-saving health care system. Nothing will ever be the same. Every day is a bonus. Life is better, for being so precious.

'She likes to say she's a tough cookie'

A few months after my surgery, I went to visit Ruth Jacobi. My roommate from the hospital lives at Kensington Gardens, on College St. in downtown Toronto. It's a long-term care facility that evolved out of the old Doctor's Hospital.

John Jacobi, her son, led me upstairs to his mother's room. It was decorated with family photographs and furniture, including a beautiful old carved wooden cabinet. (When you visit a "home," it's easy to see who has family to help them and who doesn't. Some rooms are depressingly barren; the resident sits alone, usually with a TV blaring in the corner. The average length of stay in a long-term care facility is two years, followed by death. Ruth Jacobi has lived at Kensington Gardens for five years.)



John Jacobi and his son Heiden visit John's mother, Ruth, at Kensington Gardens.

John strode briskly into the room. "Hi sweetheart, how are you?" Ruth was lying on the bed. He leaned over and kissed her; she whispered something to him. He helped her up and into a wheelchair and wheeled her into the bathroom.

The physiotherapist, Sian Owen, arrived. "I rarely come across people like John," she said, watching him care for his mother. "He's consistent, he's really here for her."

Ruth Jacobi turned 82 in April. Thanks to intensive physiotherapy carried out by Owen, she can now walk, assisted, for short stretches. She feels triumphant when she takes a step.

"She wants to walk," John said. "She likes to say she's a tough cookie."

John visits a minimum of three times a week. When he's not with her, Owen comes on Monday and Friday; and Owen's assistant comes on Tuesday and Thursday. John pays. As I was to learn in my research, the private rehabilitation he is providing is more routine for most residents of Scandinavian nursing homes, where the focus is on enhancing what people *can* do.

John also pays for acupuncture two or three times a week, to reduce Ruth's pain. "She's had incredible pain since the stroke," he said. "When she was in Mount Sinai (hospital), she was screaming in pain for three weeks. They gave her Tylenol. I had to step in. Finally got a good doctor, finally got the right meds, which really helped."

The lack of geriatricians who understand the complex conditions of old people is a severe problem. For John, the harsh reality, apart from his mother's suffering, is the realization that "there is discrimination against old people. It's the worst kind. Ageism. So many times, I'm told, 'Well, she is old. What you do expect?' It drives me crazy. It's pervasive.

The lack of geriatricians is a severe problem

"Our entire society ignores old people. We're afraid of death, yet we don't want to care for people who are aging — the place where we will be ourselves, someday."

He doesn't fault Kensington Gardens. "It's a not-for-profit, it runs on a shoestring, the people are good and caring. They do their best. But Mom asks for tea and it never comes. It's demoralizing for her."

Owen wheeled Ruth down the hall, to a sunny room where a man was seated at a computer. There was one piece of exercise equipment, called a Nustep, which Johns aid was paid for by the family of a resident. "Can you believe there was no exercise equipment in this entire facility?"

Owen helped Ruth out of her wheelchair and onto the Nustep, which is a like an elliptical trainer with a seat. Ruth sat down; Owen strapped Ruth's feet into place. "On three, Ruth, one — two —three," Owen said.

Ruth grinned and lifted her feet. She enjoyed the challenge, the exertion. "I'm a tough cookie," she said, delighted by her exertions.

Owen held Ruth's left hand, which was tightly curled into a fist, a result of the stroke. Owen massaged the hand, trying to gently open it. Ruth kept on stepping.

"If there was a pool here, Ruth could go swimming," Owen said. "We've taken her to the Variety Village pool a few times. It has the lifts and ramps and wheelchairs that can go into the water. Ruth loved it." Ruth nodded and grinned. "I love the water," she said.

(I would think of Ruth Jacobi later, when I was in Copenhagen, in a massive public swimming pool complex that had five or six pools, with access for disabled people.)

Owen smiled. "That full body sensation, floating in the water, it's lovely. You don't get that easily."

John knows how different Ruth's life could be. "If I didn't hire Sian, and if this piece of equipment hadn't been donated, Mom wouldn't get to do any exercise at all. It's odd that we put people in these environments and don't give them the ability to do anything."

When I visited Ruth, I hadn't yet been to Sweden and Denmark, and I hadn't seen a dementia home where, if you could peel potatoes, you'd be in the kitchen peeling potatoes at dinner time, or picking tomatoes in the garden, or sweeping the floor. I didn't know there were nursing homes where you could participate in the life of the home; where the rehab nurse would say, "If you can do up three buttons on your shirt, or take three steps, we'll be working with you to get to four."

Owen helped Ruth off the machine. "Stand tall, Ruth. Get your balance."

"Head up, Mom," John said. "Look at me."

Ruth Jacobi smiled and took a few steps toward her wheelchair.

"That was a long walk," she said

John applauded. "You're making great progress, Mom." His eyes were bright with encouragement. I imagined he was giving back to her what she'd given to him when he was a boy.

"I like exercise," Ruth said. "I'm happy to do it."

Back in her room, I could smell the fragrance of red roses on her bed-side table.

"Where did you get the beautiful roses, Ruth?" I asked.

"That's my Valentine," she said, kissing John on the cheek.

John turned on the radio; classical music filled the room.

"Music is my first love," Ruth said.

"My parents were poor and couldn't afford music lessons for me. John learned to play the piano. He plays very nicely." She took a few more steps and beamed.

John smiled. "She has things to look forward to. She has Sian coming, me, my wife, my son... a new baby on the way... She has hope."

- *At Kensington Gardens nursing home, rates are set by the Ontario Ministry of Health: $1,543.95 a month for a basic shared room,$2,091.45 for a private room. If you are poor, your rent is subsidized. Ruth Jacobi pays her own way.*

Portraits of aging: Mae Lewis

BERNARD WEIL/TORONTO STAR

At 92, Mae Lewis is "fine" with being old. She says Spirit the dog keeps her busy: "He's somebody to look after."

Mae Lewis's childhood in Niagara Falls was marked by the sort of deprivation that can be profoundly damaging, but Lewis survived — and today, at the age of 92, she's thriving.

Her mother died when Mae was 7 and her father, a bread man, put her out to work cleaning houses when she was 12. "Same for my sister. We 'lived in.' The second place let me go to high school, but I wasn't paid for my work."

When she was 14, she was kicked out by her employers. "I had to go to the Salvation Army and say, 'I have nowhere to go. My father doesn't want me.'"

Lewis didn't give up. She continued doing housework until she got married at 21, had one child, her daughter Beverley, and worked nights at Brown's Bread. At Christmas, she would work at the post office, also at night.

She bought a house with her husband — at last, she had her own home— and was generous with family and friends. Every year in early December, she took out a loan for $1,000 to buy clothing for her sister's four children (their father was an impoverished minister) and Christmas presents for her grandchildren. "It took me all year to pay back, then I'd borrow again for next Christmas," Lewis says.

She also bought presents for neighbourhood children whose parents were struggling; to this day, aging adults remember with gratitude that Mae Lewis bought them their first train set or doll.

Lewis's daughter Beverley Bishop, who died in 2003, was a source of delight; she worked for the former Beach politician Tom Jakobek and was well known in the east end. "Everybody loved her; she helped everybody."

Lewis worked for Sears for 25 years until she retired at 65 and moved into a seniors' building. Her husband died 16 years ago. She was fine on her own, she says, until she had a series of strokes and her doctor said she couldn't live alone anymore.

"My daughter insisted I come to live with her and the kids. I was here a year and a half when Beverley died of cancer. It was good I could be with her, to look after her at the end. In her will, she left the house to her kids and said they couldn't put me out."

She stopped cooking dinner when she was 80 and relies on her grandson Steven to do her grocery shopping.

"He's so good to me. He buys fruit for me, and we eat a lot of TV dinners and pizza. We do a lot of takeout; Chinese, Italian, Swiss Chalet."

She loves the company of Spirit the dog. "He keeps me busy during the day. He's somebody to look after. He sleeps in my bed."

How does she feel about being old? She laughs. "I don't like the wrinkles or the age spots, but I'm fine. I don't use a cane, I don't wear glasses. I still go 'round the corner to the stores, the drugstore, the dollar store.

"Every Saturday morning at 9:30, I'm the first customer at the hairdresser, for a wash and a set. Next Saturday, I get a perm. Then I'll get a coffee and a meat patty and sit here and eat it. I read a lot of Harlequin romances. I do crossword puzzles and watch game shows on TV."

Lewis is clear about what she wants as she gets older: "Independence. I don't want to go to a nursing home. I've visited friends in nursing homes. They're left sitting, doing nothing."

Does she attend a seniors' club? "My daughter took me once, for bingo and whatnot. I didn't feel at home. I'm happy on my own.

"I'm not afraid of death. I'm ready to go. I've lived my life. I've done everything I wanted. Never thought I'd live this long."

Living life to the fullest in Denmark

Lotte residents Ida Dupont, 94, and Nis Sauder, 95, enjoy lunch together.

This is their home— of course their families must be welcome

THYRA FRANK,
LOTTE DIRECTOR

WHAT THE AGED REALLY WANT:

The Danes do all they can to enable elders to stay in their own homes. And for those who are too frail, the country's nursing homes are small, homey and delightful.

COPENHAGEN - It's a balmy afternoon in Tivoli Gardens, the legendary amusement park in the Danish capital. Lots of older women are out walking in the sunshine, which surprises me and my travel companion, Toronto gerontologist Margaret MacAdam - we don't normally see so many elderly people leaning on walkers and canes, looking vital and happy, in Toronto parks.

Else, 91, beautiful in a yellow sweater and colourful scarf, relaxes on a bench with her granddaughter Karin, who translates for Else.

The two meet here once a month, Else coming by train, Karin by bike. "I used to bike a lot," Else says, "but I stopped when I turned 90 ... Still, I like to spend the day at Tivoli Gardens with my granddaughter."

A widow - her husband died 20 years ago - Else has lived alone in the same apartment for many years. She's had hip-replacement surgery and is considering knee replacement.

She recalls that when she turned 75, she had the standard outreach visit from a local nurse, who assessed her needs, offered any modifications to her apartment that were necessary, and promised to keep an eye on her, to see when she might need help at home.

Else now has a cleaner once a week and someone to help with grocery shopping. "That's all," she says, straightening her back. "I do my own cooking. I can look after myself."

Will she move to a nursing home one day? "No. I like to close the door and have my privacy."

In terms of services that elderly people actually want, Denmark - and neighbouring Sweden - are the best places in the world to grow old. Both have strong, cradle-to-grave social programs, and compete with each other - and with their Scandinavian cousins Norway and Finland - to give their citizens the best comprehensive elder care.

Danish and Swedish policies are designed to help people stay at home as long as possible through a variety of home-care services and regular house calls by doctors. In Denmark, regular monitoring of an elderly person's needs begins with a visit by a nurse when a person turns 75. "That visit has a huge impact," MacAdam observes. "It reassures and also educates the individual."

I am struck by the attitude of proud independence I encounter in many of the seniors I meet in the two countries, how they persist in doing the chores they are able to do. The system supports them where needed, but doesn't take over - not even in nursing homes, where they have kitchenettes so they can make their own toast and tea. "The philosophy is that, no matter how frail, you have a right to be in charge of your life," MacAdam says.

In the past 20 years, Denmark focused so much on home care that it stopped building long-term care facilities. Now Danes are finding they need a few, and they're leading the world in creating small (by Ontario standards) nursing homes where the focus is on what people *can* do.

Many long-term care facilities in Denmark and Sweden are homey, intimate environments where quality of life is paramount. Fresh flowers on dining-room tables, wine with meals and real camaraderie among staff and residents are among the hallmarks.

Such facilities contrast starkly with most in North America, where residents often have nothing to do. Despite the best efforts of recreational staff to organize cookie-baking or art classes, the overall paradigm of elder dependency prevails.

The quality of long-term care in Denmark and Sweden reflects their relatively generous spending on the sector. According to Organization for Economic Co-operation and Development figures, in 2005 Denmark devoted 2.6 per cent of its gross domestic product to long-term care, and Sweden 3.3 per cent. By contrast, Canada spent 1.2 per cent of its GDP, and the U.S., .9 per cent.

But Danish and Swedish success is about more than money; it's about philosophy.

As MacAdam and I toured Danish facilities earlier this year, and then I went off to Sweden on my own, I was impressed by the *engagement* of most older Scandinavians, their sense of belonging. In contrast, North American elders often feel sidelined. The ageism that is so much a part of North American society didn't hit me until I saw the vitality of older people in Denmark and Sweden.

We drop in at Frederiksberg Home Service, a public agency in Copenhagen. Simone Eliasson, a senior manager, explains that her office is responsible for the home care of 3,000 clients.

Almost one-quarter of older Danes get some level of home care, and they can choose the provider from public or private agencies. The amount of service they get is determined by the municipality's home-care manager, who assesses whether they need help with personal care, house cleaning or food preparation.

Tine Rostgaard, a senior researcher at the Danish National Centre for Social Research and an expert in care of the aged, emphasizes that "the philosophy of the Danish government is to integrate elderly people, to keep them active in the community as long as possible, to not do things for them when they can do for themselves."

If a man loses his wife, who has done all the cooking, "we will teach him to cook, instead of providing food. You should continue to learn and develop through your lifespan."

Dependency, the Danes have learned, is a slippery slope that hastens your demise. But "when you're old and frail," adds Rostgaard, "the care should come to you." Hence the routine practice of home visits by health professionals such as doctors.

The government has studied the cost-effectiveness of the preventive home visits to every 75-year-old, "and our outcome studies show they are highly effective," Rostgaard says.

Certainly, the age-75 visit means the Danes avoid a problem we face in Ontario: most people don't know what home care is available or how to access it.

Danish home-service workers visit up to seven people a day. They make about $30 an hour (in Ontario, comparable home-care employees earn about $15). It can be a tough job, says Thea Andersen, 30. After 12 years of providing personal care for elders, she's burned out.

"The government is making cutbacks," she says, "and clients can't be guaranteed to get the same worker all the time, which makes it hard for elders, having to cope with strangers coming to their home."

The Danish government *has* applied tighter cost controls on home service: the hours of care available to clients have been cut, with cleaning reduced from weekly to once every two weeks. "It used to be more relaxed," Andersen says. "If the elder was sad and wanted you to stay longer and talk, you could do it. Now it's more rigid. The worker has to watch the clock and get to the next person."

Perhaps it's the pressure on home-care workers, and the lack of social status, respect and support, that contribute to a labour shortage in this sector not only in Scandinavia but throughout the developed world. The trends are similar in Denmark and Canada: personal-support work is often seen as an entry-level job; immigrants often take these jobs, but they may have difficulty

ELDERS AND THE COST OF CARE

13.7%
current proportion of the population aged 65 and up in Canada

15%
in Denmark

17%
in Sweden

25%
proportion of the population aged 65 and up in Canada in 2050

24%
in Denmark

24%
in Sweden

$35,000 - $43,000
annual cost of nursing home care in Canada

$75,000
in Denmark

$75,000
in Sweden

1.2%
proportion of GDP spent on long-term care in Canada

2.6%
in Denmark

3.3%
in Sweden

Sources: Statistics Canada, Eurostat, OECD

Denmark, the very best place to grow old

with language skills and writing reports; elderly clients may feel uncomfortable with workers who aren't familiar with the language or culture. When dementia is part of the scenario, caregivers can be subjected to abuse.

MacAdam and I take the train to a pleasant Copenhagen residential suburb to visit Torndalshave, a group home for people with dementia. I am not looking forward to this visit. My father, who suffered from Alzheimer's, was "incarcerated" - his word - in a long-term care facility in Ottawa for five years before his death. My old friend Joyce Wieland, the artist, suffered from early-onset Alzheimer's and spent the last few years of her life bent over in a dementia ward.

Dementia is not a pretty thing, and the places I've seen in Ontario, though clean and well-run, are profoundly depressing. With Celeste, my therapy dog - she's certified to visit nursing homes, and she started me on this journey into aging when she got her first job - I've visited dementia wards; the residents mostly sit in their rooms, with a TV blaring in the corner. Or they pace. Or stare into space.

Here at Torndalshave, the mood is light and bright. Partly it's the architecture. The one-storey building is new and modern, with a courtyard garden in the centre. The inner walls are glass, floor to ceiling. Light pours in. Flowers and tomato plants thrive in the garden, where residents help out.

There are only 12 residents, which amazes MacAdam. "We would never build a dementia home in Ontario for only 12 people," she tells me. "It's great for the residents, but we would say it's not cost-effective."

The residents live in two pods of six, with two staff members caring for each pod. They have their own living room with an attached, open-concept kitchen; residents can enjoy the bustle and aromas of food being prepared, and they can help make the meals. If you can peel potatoes, you are enlisted.

Staff, along with residents, do all the cooking from scratch, plus laundry and cleaning. It's deliberate policy: to engage the people who live here to participate in household chores. If you can hold a broom, you sweep the floor. And residents can have a glass of wine at dinner. (In Ontario nursing homes, you can buy a bottle of wine, but you can't drink it in the dining room; a glass will be brought to your room if you ask.)

As in Ontario, residents pay their rent from their old-age pension. If they need a subsidy from the municipality, they get it. But unlike Ontario, where dementia wards are locked, it's against the law in Denmark and Sweden to lock people in.

The biggest surprise for me is the behaviour of the residents: they don't seem depressed. They sit in the living room, a few at a table, interacting with staff. A small terrier named Ouzo sniffs around. "Ouzo," says a man, "come here." Ouzo jumps up on his lap.

An old woman holds and rocks a doll back and forth, as if it's a baby. A few men smoke. One fellow kisses MacAdam's hand. We observe the genuine warmth between workers and residents.

Hanne Hannssan, a manager who greets residents with hugs, says she's old enough to retire. "I have a pension and I don't need to be here, but I love the work." Love the work? With dementia patients?

Residents' rooms are private and spacious, decorated with the individuals' own furniture, and include a sink, a two-burner hot plate, a small fridge and cupboards - so family members can make a cup of coffee, have a bite to eat.

MacAdam is wowed. "This is a model project. It's the Rose Kennedy School of long-term care. Rose Kennedy lived in her own home with three registered practical nurses and her family came to visit. This is as close to that as you'll ever get in a public system."

We go on to Lotte, the most famous nursing home in Denmark. We walk up the path through a beautiful garden to a large old Copenhagen villa. An off-kilter fellow of 93, one of 23 residents, steps off the elevator. He is wearing a helmet to protect his head - he has a tendency to fall - and pushing a walker. The helmet is indicative of the lively life Lotte residents lead; instead of not going out, you wear a helmet and take the risk.

The villa's big windows are open for the early summer breezes. Fresh flowers dance on all the tables in the dining room. Fancy chandeliers hang from the ceiling.

In another room, a few men watch soccer on a giant, flat-screen TV. Jan, seated on the sofa, is smoking. He takes a small pack out of his shirt pocket. "They give me 10 cigarettes in the morning, 10 more in the afternoon."

I ask what's good about the place.

I receive the answer I will hear repeatedly throughout Denmark and Sweden. "The best thing about this place is the people. This is home."

Jan moved to Lotte after suffering a brain aneurysm and a stroke. "I was lucky to get in here. The food is good. I like to go outside and walk in the neighbourhood. I play cards."

"What's special about this place is that it really is home-like," MacAdam observes. "It's not at all like an institution, and it would never be legal in Ontario. It would not meet fire safety codes; there are no fire doors. Look at all the smokers. This kind of place has been outlawed in North America."

Maybe we've regulated our nursing homes to death?

"It's true that you can overregulate facilities," MacAdam allows.

The Danish government, acknowledging that it needs more up-to-date nursing homes, is modernizing old facilities and building new ones like Torndalshave.

RENE JOHNSTON/TORONTO STAR

Jette Vesner checks in on Ingrid Nielsen, who hugs a toy stuffed dog, at the Lotte nursing home in Copenhagen. Lotte is much admired throughout Scandinavia.

The biggest, a 150-person building, is currently being renovated and downsized to hold 100. The current Danish ideal - the result of an international architectural competition - is the Flintholm Care Home, an oval-shaped building in Frederiksberg with 56 units, 13 rooms to a floor, surrounding a communal dining and living area, which means every suite has exterior windows and there are no long corridors. No long corridors is a priority. Every unit has its own bathroom and kitchenette.

The total cost of a Danish nursing-home room is about $75,000 per year, the same as in Sweden. "Very expensive," says MacAdam. "In Ontario, the total cost per person is $43,000 a year. We get better financial efficiencies from our larger buildings." And poorer quality of life.

A few days later, we return to Lotte to meet with its famous director, Thyra Frank. Dinner has been delivered: open-faced sandwiches with smoked salmon and shrimp. The staff bring out bottles of wine - good wine - and schnapps. "We cook during the week, but on weekends," says a staff member, "we order in. I love working with older people," the staffer adds. "They are so appreciative of what you do for them."

"Do you have enough staff?" MacAdam asks.

She's startled when the reply is, "Yes, we do. We have four to five staff during the day for 24 people."

"In Ontario, if you ask that question," MacAdam tells me, "you're always told no, no, we don't have enough staff."

As dinnertime approaches, residents make their way to the dining room. The piano player arrives, a spiffy showman with blow-dried hair. He plays songs the residents are familiar with. They tap their fingers and canes in time to the music.

A group of Norwegian social workers has descended on Lotte; they tell us they want nursing homes in Norway to become more like this.

RENE JOHNSTON/TORONTO STAR

A glass of wine or schnapps and even a cigarette are permitted in at least some Danish nursing homes.

JUDY STEED FOR THE TORONTO STAR

Older women in Copenhagen's Tivoli Gardens: independence is encouraged.

RENE JOHNSTON/TORONTO STAR

Nis Sauder, 95, pours himself a glass of Baileys in his room at Lotte.

Thyra Frank enters the dining room. A large, affectionate woman who hugs everyone in her path, she invites us to her table, pours us wine, insists we eat, and talks about what she believes: that all of us deserve a warm home and a sense of belonging till the day we die. Family members are always welcome to join residents for lunch or dinner, at no charge. "Of course," says Frank, "this is their home - of course their families must be comfortable and welcome."

She talks about the annual holidays for Lotte residents and staff, to Spain or Greece, involving everyone, including people suffering from dementia. The holidays are paid for out of the sick-pay fund, which Lotte is able to keep since no one calls in sick.

The adult daughter of a woman with dementia says she was surprised when her mother was taken on a trip to Spain. "I thought people with dementia were so confused, there was no point," she says. But when her mother returned, "she was happy. I could see that she'd had a good time."

The party went on late into the night, with after-dinner liqueurs served to everyone, including the residents, who stayed until the end.

Should sleep not come, they will not receive a sleeping pill. Lotte has a better idea - a glass of schnapps, or three.

Too many patients, too few doctors

SHRINKING SPECIALTY: *Canada's health-care system has just 216 geriatricians, one-fifth of those needed to treat an aging population*

Geriatricians are a dying breed.

They're the specialists who know how to assess and treat the chronic conditions of aging, but they've been neglected and underpaid for so long that medical students are shying away from a specialty that should, by rights, be booming.

Seniors are the health-care system's biggest customer and a disproportionate drain on services. More doctors and nurses trained in geriatric care could save the system untold millions by appropriately treating an aging population - and improve their care.

"An old person can't walk? The standard reaction is: Give them a walker. A geriatrician asks: 'Why can't they walk?'" explains Dr. William Dalziel, the renowned head of the Regional Geriatric Program of Eastern Ontario.

"Old people are told they're 'frail.' Geriatricians try to 'unfrail' them."

Dalziel is a geriatrician (a gerontologist studies aging). There are only 216 in Canada, one-fifth of those needed, and few of them are working with patients full-time. Many focus on research and 43 are close to retirement. There are only six geriatricians in the country under the age of 35.

"We've rarely got more than 10 doctors doing final exams in geriatrics in Canada in one year, and usually much less," says Dr. Barry Goldlist, director of geriatric medicine, University of Toronto, and medical director of the Toronto Rehabilitation Institute.

The shrinking pool of expertise comes at a time when 40 per cent of health-care dollars is spent on seniors, who represent just 13 per cent of the overall population. Studies show that when geriatric services are introduced in a hospital, bed blocking (elders stuck in hospital past their discharge date) goes down by 50 per cent.

When specialists are asked to rank their satisfaction level, geriatricians come out on top. As Dalziel puts it: "Geriatrics appeals to doctors who can embrace complexity - you're dealing with multiple conditions and social factors - and help older people regain their essence. ... My goal is to optimize the person, help them improve so they can feed themselves, instead of being fed." If a geriatrician sees a wobbly older person at risk of falling - which can precipitate a life-ending crisis - he has the expertise to check for common problems such as over medication and drug side effects. "Keeping seniors from premature institutionalization by proper geriatric assessment and treatment, can save the system millions every year," Dalziel says.

"Most doctors don't know what to do with old people who have multiple conditions. Medical students get, out of 8,000 hours of training, 60 hours in geriatrics. That has to change." In Europe, geriatrics is the second most popular specialty, after cardiology. In the U.K., there are more geriatricians than cardiologists; they're paid the same. The presence of geriatric specialists in U.K. emergency rooms has resulted in significant reorganization and dramatic reductions in wait times.

In Canada, you don't have to be a brain surgeon - or a geriatrician - to alight on obvious fixes: Increase compensation and incentives for geriatric training, which could include a reduction in tuition fees.

Medical school graduates now carry enormous debt burdens and geriatrics in Canada is a low-paying specialty, traditionally earning approximately $200,000. Cardiologists and neurosurgeons earn in the $500,000-plus range. A full-time family physician with a roster of 800 patients earns up to $350,000.

In recent years, most specialties *except* geriatrics received a pay hike from the provincial government, some by as much as $100,000. This fall, the Ontario government made up for the oversight and raised compensation for geriatricians to $330,000. But it will take time to renew the shrinking pool of expertise. At the University of Toronto, which wants to produce more geriatricians, Goldlist worries there are too few specialists to do the training.

Another fix: accelerate the incorporation of foreign-trained doctors by providing geriatrics training.

Dr. Andrew Padmos, CEO of the Royal College of Physicians and Surgeons, is worried about the deficiencies in health-related human resources planning.

Across the board, we're not producing enough doctors or specialists, and we're too slow in enabling immigrant doctors to work here, he says."There are 5,000 internationally trained doctors in Ontario who are not working as doctors."

And those who *are* working are burning out."I've been a geriatrician for 25 years and I feel like Sisyphus, constantly pushing the rock up a hill," Dalziel says. "We're exhausted. We're so far behind the Europeans." His only hope is that the baby boomers will wake up. They're assertive. They see what's happening to their parents, and they're realistic enough to realize they don't want to go there."

Dalziel is 57. In a few years, he plans to move to the West Coast and reduce his work load.

And then we'll be down to 215.

Portraits of aging: Ted Maczka

BERNARD WEIL/TORONTO STAR

"I want to tell everyone: chew two or three cloves of garlic a day and you'll be better," says Ted Maczka, 81, Prince Edward County's garlic guru.

"I preach garlic," says Ted Maczka, 81. That's what he has for breakfast every day: One teaspoon of chopped raw garlic, in the blender, with vodka to cover.

"Instant pickled," he says, blue eyes beaming clear and bright in a tanned and happy face, as he works in his garlic field in Prince Edward County, where he owns 22 hectares.

Born in Poland, Maczka spent two years as a teenager in a Russian camp during World War II where he broke his leg and hip. It was never properly treated; to this day, he has pain and walks with a severe limp.

Eventually, he made his way to Canada, where he worked as a tool and die maker. He "got into" garlic when he realized no one here was farming it, and though he only has a Grade 6 education, "I did a lot of research into the medicinal properties of garlic.

"Canada imported millions of dollars worth of garlic every year. I said, 'Why don't our farmers grow garlic?' I knew back home we could grow garlic. I knew they grew good garlic in Russia." Garlic has been used for centuries as a folk remedy and in herbal medicine, to treat the common cold; there is new evidence that it can help manage high cholesterol levels and is a powerful antibiotic.

If you're getting a sore throat or a cold, chew a raw clove of garlic, Maczka says. It will take the sore throat away. If it comes back, chew another clove of garlic.

He faced many challenges to realize his dream. His farm, which he bought in 1971, "didn't have running water unless it was raining." He put in a septic system and toilet, dug a well. A fire caused by the wood stove left him living "in a burned-out house." He had a wife - "She was a city girl. I left her there. She didn't want to come to the farm."

Three years ago, he moved into a nearby retirement home with nine older residents. He likes it fine. "I'm out here (at the farm) every day. On Sunday, I take half a day off. I'm a busy man. I have a laptop." He still calls himself an amateur farmer.

He has set up the Fish Lake Research and Experimental Station in an old yellow school bus that's rusting into the ground, packed to the windows with boxes. Arising out of the long grass surrounding his garlic field is more junk - an aged washing machine, sinks, tires, bathtubs and barrels, planted with garlic. In other containers, manure tea is brewing; he gets the manure from a farmer down the road.

The sounds of classical music waft over the garlic 24 hours a day, from a radio in the bus. He believes the garlic responds to classical music.

Who's to argue? His crop is potent. People come from miles around to get their garlic from the Fish Lake Garlic Man.

This is the way to grow old, doing what you love and not worrying what other people think of you.

He has a large ornamental garlic bulb fixed to the top of his car. Dried garlic cloves decorate the flap of his cap. He doesn't mind acting a little "crazy," he says, in his attempts to raise Canada's garlic consciousness.

"I'm happy. I feel I'm doing good. I want to tell everyone: chew two or three cloves of garlic a day and you'll be better."

WHY THEY DO IT

After a year in the trenches with geriatricians and gerontologists, I can say that almost every one I met was drawn to the field by love for an elder, usually a grandparent.

Neena Chappell, the gerontologist who set up centres on aging at the University of Manitoba and the University of Victoria, was profoundly influenced as a child by her father's father, the only family member who supported her parents' mixed marriage.

When she did her master's thesis in gerontology, then her PhD at McMaster University in the 1970s, her professors would ask,"What's a young thing like you interested in old people for?"

She would reply, "People who have lived so many years have wisdom; they've learned a lot."

Her grandfather, M.R. Chappell, was a lumber baron of his era, in Nova Scotia. He was a friend of prime minister Mackenzie King and, within the family, he was "held up as a man who believed in justice and fairness," Chappell recalls. They shared a special relationship, so special that, when he was 90 and the doctors wanted to transfer him to a nursing home, he refused to be moved until he had talked to Neena.

"My father asked him, 'Why do you have to talk to Neena?' He said, 'I know she'll listen to what I want.'" That's the heart of it.

Dr. Michael Gordon is an ebullient geriatrician at Baycrest, Toronto's health sciences centre focused on aging. Gordon grew up in Brooklyn, N.Y., where he shared his boyhood bedroom with his adored grandmother, Bessie, a Lithuanian-born rabble-rousing activist.

She was the keeper of the family history and, in turn, she conveyed it to him. "I had images of pogroms, of Cossacks and dead people, the boat to America. She finished high school in America and became an organizer for the International Ladies Garment Workers Union. I was brought up to the left of the left," Gordon says.

His grandmother had a profound influence on Gordon's life, and you can see it in his bedside manner. If you are lucky enough to be his patient, he takes your medical file, sets it aside, looks into your eyes and says: "Now, tell me about yourself. Who are you?"

In the case of Dr. William Dalziel, it was a golf-playing grandfather who made a difference.

Dalziel, chief of the Regional Geriatric Assessment Program at Ottawa Hospital, points to a photograph of his grandfather on his office wall. "That's Gramps, Burd McNiece. He lived to 106 and three quarters."

Dalziel's eyes light up as he talks about his Gramps." He had five 'hole in ones' after the age of 80. He was a banker in Saskatchewan and lived through the Depression. At the age of 75, he moved to Kelowna; at 95, he moved to Toronto, to be near his daughter." He also travelled around the world curling and he's in the Curling Hall of Fame.

It was a gift, Dalziel says, to be close to someone "who aged without being old, who was engaged in life till the end."

Guy Proulx, Baycrest's director of psychology and neuro-rehabilitation, was drawn to the specialty of geriatrics through a different kind of love. As a child, he was aware that "there was something wrong" with his father, who couldn't talk. The senior Proulx was aphasic - unable to speak - as a result of a fast-growing brain tumour.

"I wanted people to know my Dad was a person," Proulx said."He was more than what he looked like. For me, brain damage was a door to understand how the mind works." His father died of the brain tumour at the age of 48, when Proulx was a boy.

Drugged-out seniors a prescription for disaster

They are the drugged-out generation, and they're not who you think they are.

They're 80. And 85 and 90 and 95 - overmedicated seniors clogging emergency departments, blocking hospital beds and sicker than they have any reason to be.

The Number 1 drug users in North America, outside of patients in long-term care facilities, are women over the age of 65. Twelve per cent are on 10 or more meds, sometimes up to 20 or more drugs; 23 per cent take at least five drugs. In long-term care, seniors are on six to eight medications, on average.

Fifteen per cent of seniors admitted to hospital are suffering drug side effects. It's not uncommon to find seniors dizzy and dotty from being prescribed so many drugs.

"You'd fall down, too, if you were on so many drugs," says Dr. William Dalziel, a prominent Ottawa geriatrician.

Typically, overmedicated seniors have been seen by numerous specialists who have prescribed various medications to treat a host of chronic ailments - high blood pressure, hypertension, diabetes, osteoporosis, arthritis, heart disease, cancer - but there hasn't been any oversight by a geriatrician skilled in looking at the big picture and assessing contraindications and side effects. Ask doctors with expertise in seniors what their top health concerns are and they all cite overmedication.

Dr. Mark Nowacynski, an exceedingly rare family doctor who does home visits on a full-time basis, shakes his head. "So many old people are prescribed so many drugs, they don't know what they're for and they often don't take them properly," he says.

Nowacynski recalls taking care of an old man who was seeing six specialists.

"He was very anxious and confused; the specialists' advice often conflicted. I was astounded at how many meds he was on, more than 20. He wasn't taking them as prescribed and he was suffering from various side effects and interactions that weren't being monitored."

Over time, Nowacynski - or Dr. Mark, as his patients call him - was able to wean his patient down to fewer than 10 drugs.

One of the reasons overmedication is such a serious issue, apart from the biological aspects, is that seniors become vulnerable to serious falls when they're excessively drugged, and serious falls can lead to a downward spiral of hospitalization, extreme fear of going out, isolation and death. As well, many seniors have trouble sleeping; instead of being encouraged to tire themselves out with exercise and activities, they may become habituated to sleeping pills that leave them groggy during the day.

> *'Any new symptom in seniors should be considered a side effect unless proven otherwise'*

Another problem, says Dr. Paula Rochon, a Baycrest geriatrician, is that doses for older people should often be much lower than for younger people. She notes that Valium is long acting and very sedating and shouldn't be prescribed at all to seniors.

Not only does overmedication cost the health-care system millions of dollars annually in unnecessary, expensive prescriptions, but also the entire system slows down - and wait times for other patients lengthen - as emergency departments and hospitals struggle to diagnose drug-related problems.

Doctors and nurses trained in the ailments of old age and alert to the problem of overmedication can resolve many of these issues quite quickly, but most doctors haven't had any significant geriatric training. Stories are legion about elders blocking emergency rooms and being admitted to hospital, with doctors thinking the old people are having heart attacks and ordering expensive tests when the problem is simply overmedication.

In 1995, the *Canadian Medical Association Journal* found that doctors who wrote the most prescriptions also had the highest death rates among their patients.

"This study found that some doctors, in trying to maximize the number of patients they could process per day, did not take the time necessary to find out what was wrong with these patients," writes David Foot in his bestseller, *Boom, Bust & Echo*. "That kind of medical practice results in overmedicated and inappropriately medicated patients."

According to Dr. Jerry Gurwitz, chief of geriatric medicine at the University of Massachusetts Medical School: "Any new symptom in an older person should be considered a drug side effect until proven otherwise."

At Baycrest, Toronto's health sciences centre focused on geriatric care, Rochon has spent years working with the facility's doctors, researchers and residents in long-term care to find solutions to overmedication.

"When you're dealing with complex conditions (in seniors) and all these drugs, how do doctors make the right choices?" she asks. "It gets complicated for everybody."

Thanks to her efforts, Baycrest developed software for a computerized physician order entry system. Instead of scrawling, often illegibly, on a prescription pad, doctors sign in to a database and get full access to residents' medical histories and comprehensive pharmacological information, before they order prescriptions.

Baycrest's wireless networks were upgraded and the centre became the first long-term care facility in Canada, and one of the first in North America, to do its drug prescribing electronically.

"At a glance, you can look at the patients' history, get their age, weight, see what other meds they're on, see their medication history, allergies, blood work, other consults," Rochon says. "Everything you need is at your finger tips."

The U.S. Department of Health and Human Services was so impressed that it funded a landmark study to determine Baycrest's effectiveness in reducing adverse drug events in long-term care. The University of Massachusetts' Gurwitz, who was a principal investigator, stated that Baycrest was "ahead of the curve in adopting health information technology" and "there are few places like Baycrest in all of North America in which to carry out such a study."

Prescribing is now much improved at Baycrest, Rochon says, and "doctors are making better decisions because they've got better information."

Most Toronto hospitals have followed Baycrest's lead and use computerized physician order systems.

The Ontario government has responded to the issue with the Meds Check program (MedsCheck.ca), in which pharmacists are paid to assess seniors' medications and detect problems. People who have an OHIP card and are taking three or more prescription drugs for a chronic condition are eligible. On presenting their card, they receive a one-on-one, private consultation for up to 30 minutes with a pharmacist, who will make sure they are taking their drugs properly and educate them about possible adverse drug reactions.

"Some over-the-counter medications can interfere with certain health conditions and adversely affect some prescription medications," the MedsCheck website states. Decongestants, for instance, may be taken to relieve cold symptoms, but they can have the effect of raising blood pressure. Vitamin C can reduce the efficacy of chemotherapy.

Still missing, however, is a Canada-wide policy. In 2002, Roy Romanow recommended a National Drug Agency that would include a national program for managing medications to, among other things, monitor prescriptions and adverse drug reactions among seniors.

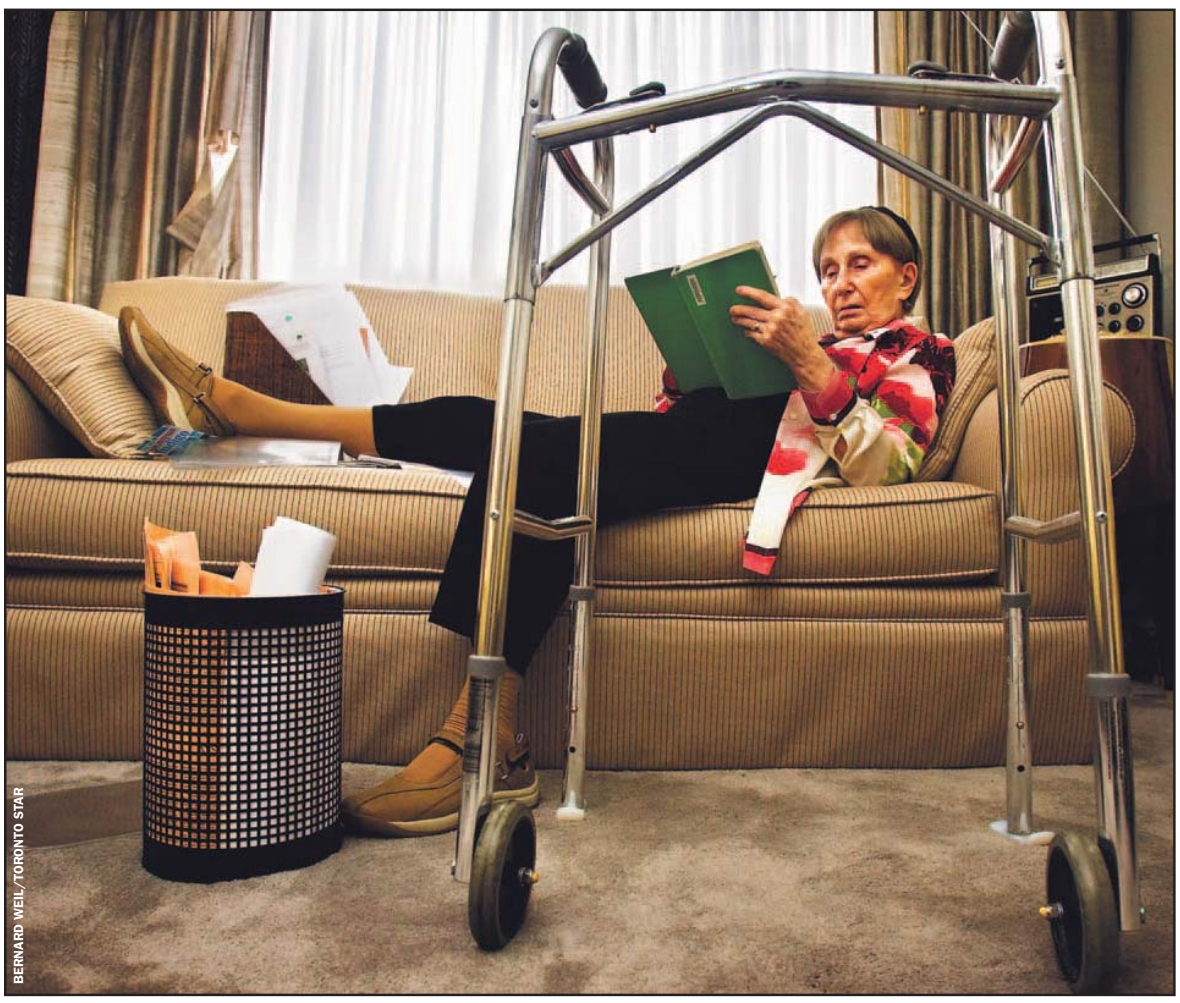
"The evidence is that new drugs come on the market every few days and in Canada there is no comprehensive process to address their safety, quality and cost-effectiveness," Romanow says.

"Health Canada says it does this, but it doesn't, not like the Food and Drug Administration in the United States."

Romanow says a national program would make a huge difference in the daily lives of seniors, the major consumers of drugs in Canada.

Six years since Romanow's prescription, it has yet to be filled.

Portraits of aging: Sylvia Ostry


BERNARD WEIL/TORONTO STAR

"I can't be alone, so I hired Aimee," says Sylvia Ostry. "If you don't have an Aimee, you have to go into long-term care."

Sylvia Ostry is seated on a sofa in her apartment high above the city, windows shrouded by curtains, surrounded by the exquisite art and objects collected by her late husband, Bernard, a top cultural bureaucrat in Canada.

"He had the most incredible taste," she says, ceding the selection of the marvellous art to him.

The Ostrys, Bernard and Sylvia, were famous among their friends not only for their accomplishments but for the closeness of their relationship. They met when she was 5, in Grade 1, in Winnipeg. They were married for more than 50 years.

He died two years ago, after battling prostate cancer that spread.

Is she lonely?

"The word 'lonely' is inadequate ... I had two things in my life: Bernie and my work."

Her entry in the *Canadian Encyclopedia* covers extensive ground: "Economist, public servant, b. at Winnipeg 3 June 1927 ... She began her career in university teaching at McGill and Oxford ... She was director, Economic Council of Canada (1969-72); chief statistician of Canada (1972-75); deputy minister Consumer and Corporate affairs (1975-78); chair Economic Council of Canada (1978-79). In 1980, she was appointed Head, Department of Economics and Statistics, OECD, Paris ... Since 1985 she has been an ambassador for multinational trade negotiations. Called 'the ultimate public servant, ' she has contributed especially in the areas of labour economics, manpower studies and productivity. In 1987, she was given the Outstanding Achievement Award, the highest award for public servants."

Sylvia Ostry is 81. She had a stroke on Jan. 10, 2007. "I was in Paris, going to a meeting of economists. It was an important topic: The business of subsidizing biofuels. I had breakfast with a few colleagues and went back to my hotel to get my coat. I went to the bathroom and fell to the floor, paralyzed. I screamed for an hour. Nobody heard me. Finally, my colleagues found me on the floor. I was totally paralyzed on the right side of my body.

"But I'm lucky. I'm not deaf or blind. I was in the rehab hospital here for nine months, I did exercises every day and I came home in a wheelchair. I can't be alone so I hired Aimee (Secerio) from an agency. If you can't afford an Aimee, you have to go into long-term care."

Talking about her past life, she notes that, "When Pierre Trudeau appointed me the first female deputy minister in Canadian history, the headline in the Ottawa paper said, 'Blue-eyed mother of two, first female deputy.' I wrote a letter to the editor, to correct them. 'My eyes are green, not blue.'" She laughs.

Her mood shifts.

"I've lost so much, it makes me sick. Aging, loss, illness - what do people do when their work is over? Play golf? I had lots of friends but nobody close except for Bernie."

We talk about things she could do. I suggest the Academy for Lifelong Learning at the University of Toronto. Later, I ask someone from the academy to call her.

I checked in with Ostry recently. She was excited. "I'm taking two courses. The Byzantine and Ottoman empires, and Noam Chomsky. I've got a pile of books and I'm reading like mad. It's fascinating. At the Academy, you don't just sit there and listen to lectures, you participate, you share what you've learned about the topic. I love learning new things."

SECRET SHAME:

Toronto now has a safe haven for seniors abused by their own families

BVINCE TALOTTA/TORONTO STAR

Ontario "hasn't developed the capacity to work with older abused people," says Lisa Manuel, whose Family Service Toronto team provides counselling to seniors and their caregivers. In September, Family Service Toronto opened Pat's Place, a safe haven for abused elders.

"On the topic of elder abuse, society is back where we were with woman abuse in the 1970s," says Lisa Manuel, whose Family Service Toronto team provides counselling to seniors and their caregivers.

"Elder abuse is such a hidden problem, such a sensitive issue," but more seniors are ready to bring it out of the closet, she says.

Earlier this fall, the Family Service Toronto opened Pat's Place, a bachelor apartment to act as a safe haven for abused elders.

But Ontario "hasn't developed the capacity to work with older abused people," Manuel says. "Family Service Toronto is the only agency that has a safe haven for seniors. We've got the expertise and we collaborate with the Advocacy Centre for the Elderly (legal aid clinic). They will call us and make referrals to assist their clients."

A woman may have been abused by her husband; when he dies, his adult children may continue perpetrating the abuse. "Maybe they were abused too, and blame the mother. The mother feels guilty. We're often dealing with generational trauma."

Admitting to being a victim is hard. "People are ashamed they've 'let' it happen. They think they're to blame."

Experts estimate that at least 10 per cent of seniors are abused. "What we're seeing is that, year over year, more elders are identifying that, 'this isn't right, ' and they're reaching out for help."

Primarily, Manuel's team deals with abuse perpetrated by adult children on their parents. The abuse can be physical, psychological, emotional, medical, financial or plain neglect.

"Sometimes abused older women will say, 'I gave birth to him, I did something wrong, I'm to blame, it's my fault, I'm the parent, I have to sacrifice myself.' The abusive adult child will think, in terms of financial abuse, 'You're going to die anyway, I need the money now, I'm going to take it.'"

Once the money is gone, it's gone, Manuel says. "We have to catch the adult child selling the house out from under the older parent in order to get anything back."

Abuse of older adults was first identified by doctors in England in the 1970s, when an old woman was brought to a hospital with signs of physical abuse. Awareness spread of "granny bashing," and now, in the U.S., professionals are required to report signs of abuse - but not in Ontario. "Why is that?" Manuel asked. "There is an automatic requirement to report the abuse of children in Ontario, but not the abuse of older adults?"

The answer: Ageism is like racism and sexism; when it's all-pervasive, it results in a particular category of people being treated differently.

"It's insidious. Older people get a different reaction from society. If a 72-year-old is being abused, the system will question, 'Is she reliable? Is she capable of making decisions?' Ageism undermines older people."

In some cases, adult children who have lost their jobs move back home with parents, expecting them to die, but when the parents live on, they may be abused.

"Victims are mostly mothers, but some fathers get abused," Manuel says.

Why doesn't the abused older parent do something?

Manuel understands the dynamics all too well: She also runs the violence against women team, and she sees similar issues in elder abuse: "The victim is usually dependent on the abuser, and can't imagine being free of the situation in which they're trapped." Just as an abused woman can't imagine being liberated from an abusive husband," it's hard for a parent to sever a relationship with an adult child. It's difficult for them to think about what to do while embedded in the situation."

Hence the creation of Pat's Place, which opened in September, to give elderly victims a place to get emotional and physical distance from the problem, to get some sleep, some food, and to experience what it's like to be outside the abusive relationship. They can stay for up to 60 days, rent-free.

Pat's Place is modelled on a similar project in Edmonton, where the city provides seven apartment units for abused elders in a larger building.

In a year, Manuel's elder abuse team - up to six people - deals with 100 cases. They cover all of Toronto. The socio-economic status of victimized elders is "hugely variable. It happens in all walks of life. Some are on full pensions and lose all their money; cheques will be diverted to the point that the elder can lose their home. We've had to phone pension offices to report fraud, pension cheques being signed fraudulently."

If the elder abuse team has reason to believe an older adult is at risk of immediate harm, they can report the case to Ontario's Office of the Public Guardian and Trustee. "If we believe the older adult is not able to take care of themselves, an investigation will be launched."

If seniors want to continue the relationship with an abusive or domineering child, they do. "We see that as their decision."

If you need help, call 416-595-9618.

Abusers, and the abused

UNIQUE TENSION: *In the world's most multicultural city, the patient is often white, while the low-paid job of personal support worker often goes to a visible minority. Racism rears its ugly head more than we'd like to think*

It's the dark side of life in nursing homes: elderly residents who punch, kick, hit and bite their personal care workers. Residents who spit and curse and call their workers unspeakable names.

"I love my residents and most of them appreciate me," says Eulalie Thompson, a Toronto personal support worker who has worked in nursing homes for more than 30 years.

"But, every day, somebody acts out, hits, calls me 'black bitch, nigger.' What can you do?"

Toronto nursing homes have a unique tension: Older residents were born into a time when racism and bigotry were more common and interaction among people of different races and cultures was rare.

But in the world's most multicultural city, the lower-paid job of personal support worker often goes to a visible minority. The clientele is often white.

"In the GTA, this is a multicultural, non-white workforce," says John van Beek, a spokesperson for Service Employees International Union Local 1, whose 50,000 members are dedicated to health care and community services.

"When you have a limited amount of time to get 16 people up, washed and dressed and into the dining room for breakfast, and you've got demented Alzheimer's patients, of course it's going to be tricky."

As he sees it, the personal support workers are rushed and the residents understandably get upset. "My dad was in a nursing home for the last nine months of his life, with dementia. He was 85 and if anyone approached him quickly, he would raise his cane. He was alarmed; he didn't know what was going on. He was still quite strong - and no one had ever laid a hand on him in his life."

In the course of the year-long Atkinson Fellowship to study aging, I have visited dozens of nursing homes. I've observed white elders rolling their eyes and denigrating nursing home staff on the basis of their skin colour or accent.

"I don't like being touched by her," an elderly white woman said of a gentle caregiver who hailed from the West Indies. A man who requested my help in calling a seniors' residence hung up the phone quickly. "Did you hear that voice? I can't stand that accent. I wouldn't go to a place like that."

Frail seniors are vulnerable and dependent and can be understandably reluctant to let strangers care for them. The personal support worker's relationship with patients is highly intimate, often involving bathing, changing diapers and grooming.

Most - but not all - seniors are appreciative. In addition, there's the unpredictable impact of Alzheimer's disease, which can afflict up to half of people over 85.

"Working in Canadian long-term care is dangerous," states the opening line of a study led by York University professor Pat Armstrong.

Out of Control: Violence Against Personal Support Workers in Long-Term Care is the result of surveys and focus groups carried out by Armstrong's team of researchers over the past year.

They uncovered disturbing reports of violence aimed at Canadian nursing home workers "virtually every day."

"Violence is part of the job - we're expected to take it," says Wendy Hawthorne, 36, a personal support worker in an Ottawa-area nursing home.

"You're hit, kicked, slapped, shoved and yelled at. You get verbal abuse from family members, too. They're upset that their loved one isn't happy, isn't the same person she used to be.

"Well, we can't change that."

Armstrong's team carried out national and international comparisons, studying nursing home violence in Manitoba, Nova Scotia and Ontario; and in Denmark, Finland, Norway and Sweden.

In Canada, personal support workers are almost seven times more likely to experience violence on a daily basis than workers in Nordic countries.

"Clearly," the report says, "the high level of violence in Canadian facilities is not necessary and can be reduced."

In Denmark and Sweden, I observed that the atmosphere in nursing homes was more positive and uplifting than in Canada; during the day, residents were usually clustered in common areas, interacting with staff in a relaxed way. Workers did not complain about being short-staffed - an important factor in quality of care and working conditions, Armstrong found.

"Nordic long-term care workers also experience greater flexibility on the job and greater communication among colleagues - both factors that mitigate workplace violence."

Armstrong's study suggests the poor working conditions in Canadian nursing homes constitute "a structural violence that originates in large measure in the way long-term care is organized and funded."

Thompson, the Toronto personal support worker with 30 years' experience, would agree. She works in a 150-bed facility; the majority of residents have dementia.

"The reason they act out, usually, is due to the staff shortage; they have to wait so long for someone to come, they get frustrated and angry. I understand that."

Thompson is skilled at defusing tension.

"I'll say, 'Honey, I'm so sorry, we have to be in the dining room and if we're not, we'll be reprimanded.' Most of them understand. Every day, they tell me, 'It's not fair that you have to be so rushed.'"

But then there are the situations she can't defuse, the bubbling bursts of anger from demented residents who strike out at the nearest hand - which often happens to be hers.

She has reported some of these incidents, but "the answer always is, 'It's their sickness, their mental instability, they don't know what they're doing or saying.'

"The implication is, we're supposed to take it, it's part of the job."

Armstrong's study noted that at one Winnipeg facility, of the estimated 15,000 incidents of violence against workers over a six-month period, less than 1 per cent were reported. Why don't workers report violence?

According to the study, workers receive little proactive training or support, they are required to fill out forms that might seem too complicated, especially if English is not their mother tongue.

And they are intimidated by a culture in which supervisors dismiss "incidents" and often treat workers as if they are to blame, as if violence is part of the job. The average wage for personal support workers in nursing homes is $17.78 per hour.

The Ontario government is planning to introduce some form of regulation dealing with workplace violence but the SEIU's van Beek says "as long as there are staff shortages, there will be violence."

"The workers have respect for patients and want to give them comfort, but there is no time for even a 30-second chat."

Thompson says that despite the dangers, she loves her work with old people. "It's my passion."

Inconceivable, perhaps, given what she experiences day-to-day. But growing up, she was close to her mother and grandmother.

"And I recognize that I'll be old myself, one day."

Portraits of aging: J.C. Sharda

BERNARD WEIL/TORONTO STAR

"Why are you living?" asks Jagdish Chandra Sharda, a.k.a. Shastri ji. "You're not just lying in bed waiting for death. You must make society better."

Offering goodness as 'flowers of faith at God's feet'

Jagdish Chandra Sharda lives above the Hindu Institute of Learning, which he founded in 1989. It's a modest storefront facing the Price Chopper near the corner of Dundas St. W. and Bloor St. W.

Shastri ji, as he is known, is a Sanskrit scholar as well as a teacher of Sanskrit and Hindi. He is 89.

He leads me into his living room and sits down - back erect, posture perfect, eyes bright. "Only my knees bother me," he says with a smile.

Asked for the secret of a healthy old age, he replies: "I will tell you a story. It is true."

"In Kenya, where I lived before I came to Canada, there was a tea plantation, a beautiful place, and an old African man who lived there. He was 105 years old. His hearing and his eyesight were good and a journalist came to interview him and asked, 'What is the secret to your longevity?' The interpreter said, 'He wants to know the secret of your long life and good health.' The old man responded, through the interpreter. 'It's easy. Never stop breathing.'"

Shastri ji laughs merrily. "My answer is different. When you retire, my philosophy is, you must fix a goal for yourself. Why are you living? You're not just lying in bed waiting for death. You must make

society better, in your own way. Serve humanity. This is my way of worshipping God.

"When you have sacred goals, God is with you. But first you must have a goal and you must wholeheartedly pursue it - any goal that makes the world around you a better place to live. Do it as a service to God. I think about God constantly."

What is his concept of God? "Eternal truth. Consciousness. Bliss. In the form of light. No beginning, no end."

Raised in a spiritual culture in Punjab, Shastri ji's father was a physician who practised Ayurveda, a system of traditional medicine, and a renowned astrologer. Ayurvedic books are written in Sanskrit, the world's oldest written language, "and my father chose me, one of six sons, to become a Sanskrit scholar, to follow Ayurveda."

Shastri ji came to Canada in 1981, after a career as a teacher in Kenya.

"I was only 58 years old. I was quite healthy. At the Ossington subway station, I would run up and down the stairs and people laughed at me. It was good for my heart."

In a coin laundry on Bloor St., he put up a notice offering to teach Hindi or Sanskrit. "One Canadian lady and one Indian from Trinidad responded and I started the class with two people. The Canadian lady was the wife of an Indian and she was so good she eventually became the secretary of the institute."

He got a job teaching Hindi in three public schools and taught night classes at Jarvis Collegiate for 15 years, until he was 75. "The students were two-thirds Canadian and one-third Indian and they requested that I continue teaching them so they could advance to the next level. That's why I started the institute."

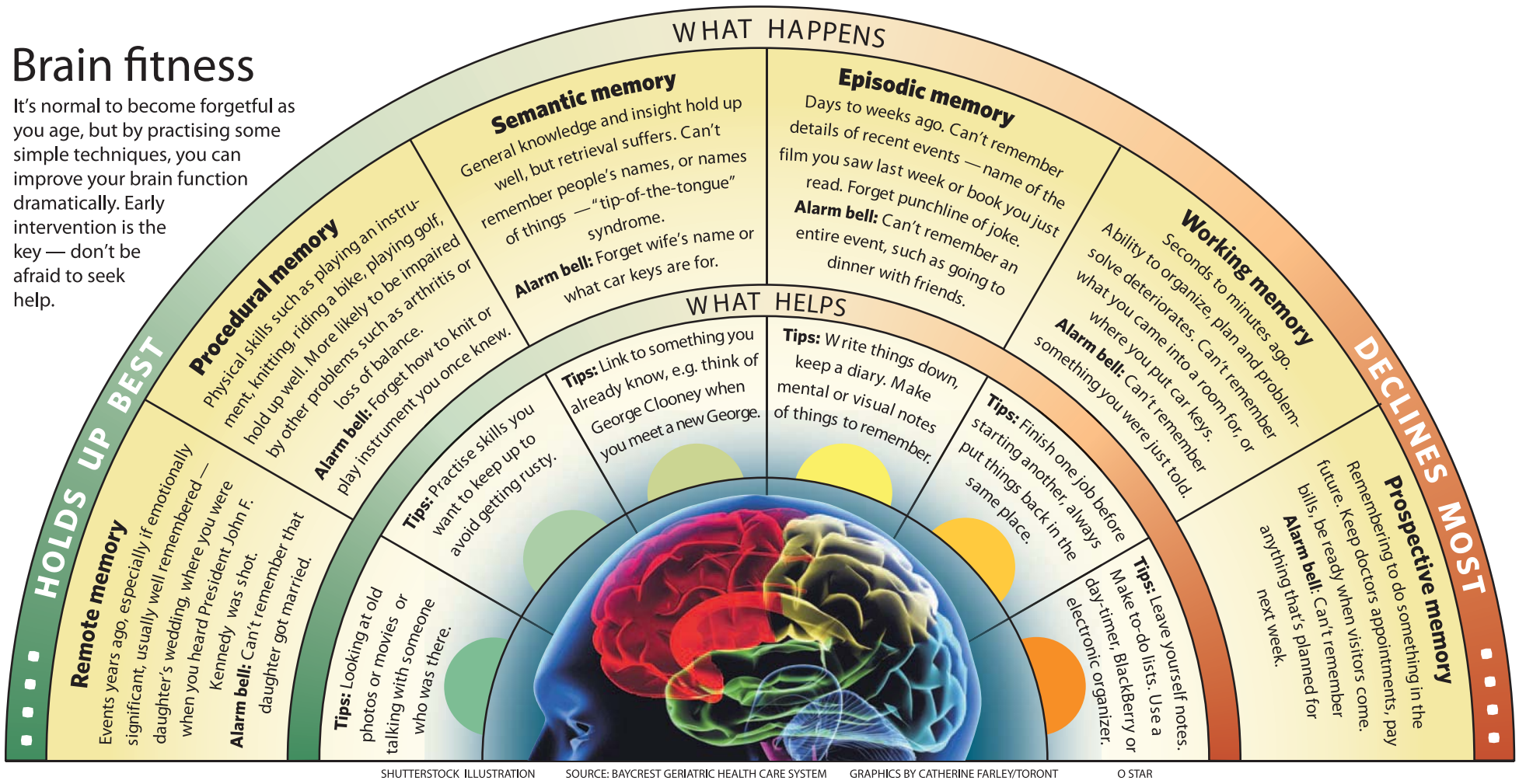
He says he has a lot of fun with his students. He particularly enjoys the rivalry between his Slovenian and Russian students, who try to outdo each other identifying the hundreds of words of Sanskrit origin in their mother tongues.

He has five children, two of whom live in the Toronto area and provide him with food. His wife is dead.

Does he fear loneliness? "No. I've never been depressed. I never lose my chi (life force), my smile, my heart. I never feel alone. God, the greatest power, is always with me, sitting in me.

"When I turn off the light at night, I say in Sanskrit, 'Oh God, whatever good things I did today I offer as flowers of faith at your feet; whatever I did wrong, excuse me."

Yes, you can: Brain plasticity



MEMORY: *Scientific research into neurological function has an uplifting message these days: It's never too late, and there's a lot you can do to preserve, and even improve, how your brain works. Because there is no joy in living a long life if your brain is in no shape to enjoy it*

"You *can* teach an old dog new tricks," says Dr. Donald Stuss, a leading neuroscientist. "The brain can potentially grow new cells and make new connections."

Until quite recently, medical science held that the brain, when fully developed, was "a finished deal," Stuss says. Now we know - thanks in part to the groundbreaking insights generated by Baycrest's Rotman Research Institute, where Stuss is director of research and senior scientist - that there is still much to learn.

Case in point: the brain's plasticity. The newly discovered extent of the flexibility and adaptability of our grey matter means "the brain can reorganize, brain networks can change, the brain is not a fixed, limited system," Stuss says. "The brain can generate new neurons and more brain regions can be recruited, brought into play, to help us as we get older."

This knowledge - gained through imaging technologies that show us the brain in action, letting us watch different regions of the brain light up, enabling the measurement of magnetic changes in neurons - has revolutionized scientists' approach to the brain, transformed medical education, and given us hope of delaying, if not preventing, brain dysfunction.

"Different areas of the brain can take over when others are damaged," Stuss says. "The brain can recruit capacity from other parts of the brain."

To take advantage of these incredible new findings, we have to change how we age.

We have to learn how to stimulate our brain in order to keep it healthy into advanced old age.

These are the odds: over the age of 85, between a third and a half of the population will develop dementia, in the present circumstances.

This is what longevity can mean: long years of not knowing what's going on, not knowing who you are.

Aging boomers may boast about their prospects for unprecedented longevity, but the harsh truth is that you can't enjoy old age if you haven't got the healthy brain to go with it.

At Extendicare Lakefield - a typical Ontario nursing home, just outside Peterborough - 86 is the average age of admission, and 85 per cent of residents have dementia.

But it doesn't have to be that way.

That's where the astounding new brain research comes in. The future of neuroscience lies in the exploration of brain regeneration.

Given the demographics - all the aging baby boomers living in fear of dementia, eager to be the first generation to benefit from the new research - and all the money flowing into brain research at advanced scientific facilities around the world, it's no wonder brain researchers can barely contain their excitement.

Thanks to the revolution in brain imaging, modern neuroscience is poised to penetrate the ultimate mysteries of the brain: how memory functions, what causes dementia, how brain deterioration can be prevented.

"There's a whole host of new therapies coming down the pipe," says Dr. Max Cynader, director of the Brain Research Centre at University of British Columbia. "We're the lucky ones."

We're in the right place at the right time, if we live long enough.

Certainly Cynader's Brain Research Centre is benefiting from the unprecedented passion for figuring out the brain. His centre has received upwards of $37 million since 2007 from government and private sources, enough to recruit some of the finest minds in the world.

"Health is more than the absence of disease," Cynader says. "What mechanisms in the brain enable us to age well? How can we avoid neuro-degenerative dysfunction?"

These questions signal a profound shift: from studying advanced brain failure - people with Alzheimer's disease - scientists are turning their attention to preventing dysfunction, supporting brain health, lowering the risks of brain disease - just as we've learned how to prevent heart disease.

After 25 years studying Alzheimer's disease, Dr. Gary Small of UCLA's world renowned Brain Research Institute, is embracing the shift. "It's easier to protect the healthy brain and treat it earlier, rather than trying to treat the brain already damaged (by dementia)."

Small is at the forefront of another development in brain research: "the digital divide," in which "digital natives" - kids who've grown up with technology - are worlds apart from "digital immigrants" - older folks.

Small's results, recorded in a new book entitled *iBrain: Surviving the Technological Alteration of the Modern Mind*, are startling.

For instance, he found that young men who play violent video games have "an impaired ability to recognize human facial expressions."

Our use of technology, and the way it "distracts from our human experience of face-to-face contact," he asserts, is having a profound impact on the actual wiring of the brain.

More proof of the brain's plasticity - and more uncharted territory for brain researchers to explore.

Portraits of aging: Beth Cada

'Making music with other people is a joyous place to be'

Beth Cada, 66, played the piano as a child - "I got my Grade 8 piano" - but felt it was a lonely way to make music. She spent her working years as a librarian, always wanted to be a musician, but life took her in other directions - until she retired.

In 2001, she joined the New Horizons Band in London, Ont. The band is part of a widespread music program that was started at the Eastman School of Music in Rochester, N.Y., in 1991 by Ray Ernst. He figured that learning to play music wasn't just for youngsters and that older people should be able to enjoy the pleasures and intellectual stimulation of music.

"I didn't know how to get back to music until I heard about the band," Cada says.

London's New Horizons' band program is based at the University of Western Ontario and it's the largest in Canada. On her first foray, Cada found a collection of rented instruments for newcomers like herself, and university music students to teach the older adults. Cada, who is among the younger members of New Horizons, had been thinking that she would choose the violin "but there are no strings in a band," so she opted for the French horn. Does she like it?

"It's like a love affair. It really is," she says without hesitation. "I love the instrument, I love the sound, the learning, the fun of being in a band. It's like learning a new language.

"What a social place a band is. I didn't know. Making music with other people is a joyous place to be."

The band is divided into beginner, intermediate and advanced with more than 200 people participating. Members are organizing their third trip to Europe next summer.

Cada went to band camp on Lake Michigan last summer, and took a blues course. The band also engages in exchanges: in June, 2007, the London band hosted the Peterborough New Horizons band and later the London group went to Peterborough.

A break from practising French horn for Beth Cada, a member of London, Ontario's New Horizons Band, means an opportunity to cuddle cat Orlando.

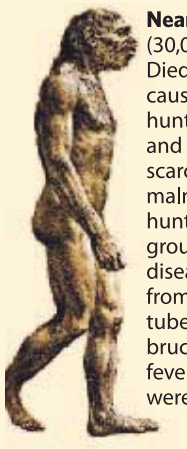
"Music has taken over my life," Cada says. "Every year, it gets better. The conductors keep giving us more challenging music and the learning curve is very steep. We have so much fun - and anything that gives you such a sense of achievement is transforming."

LIFE EXPECTANCY THROUGH THE AGES

Early humans did not generally live long enough to develop heart disease, cancer or loss of mental function. A snapshot of how life expectancy has changed, and the big killers of each era:

AVERAGE LIFE EXPECTANCY

30 years



Neanderthals (30,000 years ago): Died of injuries caused by rock falls, hunting accidents and conflicts. Food scarcity led to malnutrition. These hunter-gatherer groups contracted diseases that spread from animals. Rabies, tuberculosis, brucellosis, yellow fever and encephalitis were widespread.

38

Neolithic (8500 BC to 3500 BC): Agriculture, irrigation and urbanization brought problems associated with settled populations, such as fecal contamination of water and diseases such as cholera, smallpox, typhoid, polio and influenza. Malaria and other diseases carried by mosquitoes and insects, which fed on domesticated animals, appeared.

35 **Classical Greece and Rome** (500 BC to 500 AD): Tuberculosis, typhoid fever, smallpox and scarlet fever spread among the denser urban populations. Malnutrition, gastroenteritis and violence were also big killers.

48 EARLY MEDIEVAL **38** LATE MEDIEVAL

Medieval period (500 AD to 1500 AD): Life expectancy grew with urbanization, but famine caused by crop failures and bubonic plague were the big killers. The Black Death (1347-1351) wiped out 25 million people in Europe and 60 million in Asia, returning several times, culminating in the Great Plague of London (1664-1666). By 1500, life expectancy had dropped back to 38.

40

Victorian (1850s to 1900): Typhus, typhoid fever, rickets, diphtheria, tuberculosis, scarlet fever and cholera raged in crowded cities.

MEN **70** WOMEN **75**

1900s: Better health care, sanitation and living conditions boosted life expectancy to 70 for men and 75 for women by 1950.

CANADA: MEN **82** WOMEN **85**

Today: Cancer, heart disease and stroke are the biggest killers in the developed world. Our longer lifespan also comes with unprecedented loss of mental function and mobility problems.

RESEARCH BY RICK SZNAJDER/TORONTO STAR LIBRARY SOURCES: JOURNAL OF POPULATION RESEARCH, PRINCETON UNIVERSITY, STANFORD UNIVERSITY, WORLD HEALTH ORGANIZATION

Living well is the best revenge

Baycrest CEO Dr. William Reichman chats with resident Irma Singer, 86, in the Centre's airy Jack Diamond-designed atrium.

Toronto's Baycrest sets the bar for living with good health into old age. Some come here to die. Others to live.

This is the tension at the heart of Toronto's own Baycrest, a world leader in care, research and innovation for the aged, where the polarity of living and dying sparks an energy all its own.

First, the centre. Bustling with life, a beehive of every sort of activity linked not just to aging, but living: sit in the Jack Diamond-designed atrium, which brims with natural light and plants. Buy a coffee at Second Cup, wander around the corner and say hello to parrots Scarlett and Rhett, who've been keeping company in a gigantic cage for years. Admire the brilliant Canadian art, buy a hand-knitted baby blanket at the market for your newest great-grandson.

It's all very lively and down-home, but also hi-tech and research-intensive. Out of an annual budget of $130 million, Baycrest dedicates $15 million to research, with 85 scientists and 47 graduate students working on 183 projects related to aging.

When Dr. William Reichman, a leading geriatric psychiatrist from New Jersey, was offered the job of CEO last year, he had no desire to leave his comfortable life at Princeton University.

But a colleague who knew better - the head of the Aging Branch at the National Institute of Mental Health in Washington - told him, "Bill, go to Baycrest. It's one of the few places in the world where you can make a difference in people's lives and have a broader impact on the world of geriatrics."

Reichman came, and is pressing for a huge shift in focus: "The final destination is old age," he says.

He believes we should pay less attention to the destination and more to the journey. "Aging is a lifelong process. If we paid more attention to caring for ourselves when we're young, the typical view of old age would be very different."

That's where the living part comes in.

More than 1,000 seniors - many of them drawn from the surrounding Jewish community - live within the Baycrest system, created in 1918 as the Jewish Old Folks Home.

They can occupy one of 120 units in a life-lease condo for independent seniors aged 65 and over; when they no longer need their unit, they can sell "the right to occupy" at market value.

And they can "graduate" to long-term care (472 beds), or be transferred to Baycrest's 300-bed hospital.

Baycrest's approach is to target specific issues that can change lives. Early on, a special clinic was for people with swallowing disorders, which can cause seniors to be institutionalized.

Among its other specialties: dental and hearing clinics, mobility and seating, and a gait clinic (helping people to walk safely reduces falls); wound care and the Brain Health Centre for disorders related to memory, stroke and mood.

From the outset, Baycrest paid special attention to emerging research on the brain. "We had to pick one area of focus," former CEO Stephen Herbert says.

The centre's strategic planning committee was headed by Joe Rotman, a successful businessman who hadn't yet donated the money that put his name on Baycrest's Rotman Research Institute.

Devoted to the aging brain, the Rotman Institute has given Baycrest a worldwide reputation for leading-edge research; in the last decade the field has exploded, enabled by groundbreaking new imaging technologies.

Which has led to the development of cognitive rehabilitation strategies and interventions that help people maintain their independence, even with dementia. "As we confront the demands of the aging population, we have to confront the epidemic of Alzheimer's disease," says Reichman, a dementia specialist. "It's taken us too long, as a society, to focus on this."

Just as we've learned to pay attention to heart disease in its early stages - and, more significantly, to prevent it - we must intervene in mid-life to prevent Alzheimer's, he says, "instead of focusing on advanced brain failure in 85-year-olds."

We've also been late to recognize, as a society, "that what's good for the body - exercise, nutrition, keeping cholesterol levels and blood pressure down - is good for the brain."

Scientists now know that Alzheimer's takes root "decades before its symptoms are manifest," Reichman says.

"The brain changes occur long before - which means that ultimately, the treatment of Alzheimer's will be treatment for our boomer generation, not for our parents."

It is critical to identify the earliest signs and design interventions, as Baycrest is doing. He points out that Alzheimer's was described as a disease in the early 1900s, and it wasn't until the 1960s that scientists realized hardening of the arteries was not the cause of senility. "Here we are, 40 years later, and we have a long way to go. Baby boomers are going to demand action.

"In three years, the eldest boomers turn 65. In 15 years, the number of people over 65 will double in North America. Society as a whole has no clue how we're going to handle that."

Baycrest, Reichman believes, will take the lead with programs such as its "emergency department diversionary program that could be rolled out across Ontario. As you know, 20 per cent of hospital beds are filled with older people who are waiting for rehab, for nursing home beds, for home care. They should not be in hospital."

Ultimately, Reichman says, "we've got to focus on wellness and prevention.

"My hope is that if you enter a nursing home at all, instead of it being for the last three or four years of your life, it would be for the last three or four weeks."

Dr. Mark and friends

DR. MARK NOWACZYNSKI PHOTOS

Some of the patients that Toronto's Dr. Mark Nowaczynski sees — and photographs — during his house calls. Many don't get out much these days; some have refused hospitalization. So Dr. Mark comes to them. "As far as I know, I am the only physician in Ontario doing this work full-time," he says.

HOUSE CALLS:

In an era where economics and patient backlogs mean speedy, less-personalized doctoring, one physician blazes a new way: old-fashioned conversation and caring where you can't hear the clock tick

Dr. Mark Nowaczynski - hereafter referred to as Dr. Mark, which is what his patients call him - sees them before they die, and he wants us to see their "hidden world," too. That's why he takes photographs of his patients - beautiful, dignified, soulful portraits, in black and white.

And that's why earlier this year he agreed to take me out on house calls with him for a day, to see what he sees. "As far as I know, I am the only physician in Ontario doing this (home visit) work full-time," he says. "What I do is provide primary care for frail seniors."

FIRST STOP, John, a Korean War veteran in his 80s who came to Canada from Ireland and lives in an apartment near Yonge and Eglinton. "He's a reclusive hermit. He has some cognitive impairment, probably related to lack of stimulation."

John showed up at St. Mike's emergency with sore feet and was eventually referred to Dr. Mark.

The doctor warns me: "John hoards. He's set up a defensive trench to walk through all his stuff. Normally, our system deals with people like John by institutionalizing them. He's challenging to help, but he still has his life. He's very gentle, almost a lost soul, a delightful man."

We arrive at John's building, together with Leslie Hogg, an occupational therapist with SPRINT (Senior Peoples' Resources in North Toronto). John lets us in: it is a hot day, he is wearing two wool hats and layers of clothes, sweaters, a dressing gown, heavy boots. There are piles of stuff everywhere - a ratty curtain hangs askew, there is neither a phone nor a television set. His fridge is nearly empty.

The scene is astounding: the extreme eccentricity of the patient, the tenderness with which Dr. Mark and Hogg care for him. They are gentle, they accept him as he is; they help him.

Dr. Mark pulls out his laptop and makes notes as he takes John's blood pressure and checks his heart. (The electronic records are shared by SPRINT's health team, including Hogg, a social worker and a nurse.)

"John has an irregular heartbeat," Dr. Mark says. "We started him on aspirin and a beta blocker."

Hogg counts John's pills, notes that he has taken the correct number, and tells him it's time to sign post-dated rent cheques. (John was nearly evicted once when he fell behind on his rent.) He searches for his chequebook, and amazingly, extracts it from a pile on the table.

Hogg writes out the cheques; John signs them.

I think to myself: a country where this man is taken care of is a good country.

NEXT STOP: Clarence, 91, referred by Meals on Wheels; hadn't seen a doctor for 30 years, has congestive heart failure, would have died in the fall of 2006 if Dr. Mark hadn't seen him. "He's frail, doesn't get out much, refused a walker," Dr. Mark says, parking in front of a run-down semi-detached house.

Clarence is seated in a chair in the living room. He swims in an undershirt: he is skin and bone.

"I creep around," Clarence says. "I can no longer go out. I'm afraid of tripping and falling. But my stepson comes every Tuesday and takes me grocery shopping. That's my one and only excursion into the outside world. My granddaughter comes once a week and brings me coffee. I am most fortunate to have them. They make living worthwhile."

Dr. Mark takes Clarence's blood pressure. "How's your breathing? How's the swelling of your legs? You sure you don't want to try a walker?"

Enjoying the company, relaxing as Dr. Mark attends to him, Clarence talks about his life, "I was an accountant."

"You were the CFO of an oil company," Dr. Mark says.

"I find living rather tedious," Clarence says. "I get Meals on Wheels. Not too tasty. The squirrels and raccoons get it."

Cobwebs hang from the ceiling, dust piles on the floor. I ask Clarence if he'd like help cleaning the house: "I don't see where the place is getting dirty," he says.

As we leave, Dr. Mark says it's not uncommon for patients to refuse a cleaner or other assistance. "They're too proud to admit they need help. They don't want to be seen using a walker. They think, 'That's for old people.'

"He's nearly 92."

EMILY, 97, answers the door of a pristine midtown home. She holds onto her walker. This is a decidedly upper-class house, inhabited for many years by three siblings, all in their 90s. Dr. Mark has come to see Kathleen, 95, who is bed-bound upstairs.

Bienne, a personal support worker from SPRINT, is with Kathleen in the bathroom. Kathleen is as frail and bony as a baby bird, hunched with osteoporosis. She cannot stand up or walk on her own, and the curvature of her spine bends her neck, making it difficult for her to speak or eat. She wears diapers; her hair is in rollers.

"She likes to have her hair curled," Emily says.

Bienne manoeuvres Kathleen onto a push chair and into the bedroom.

Under the rules of the province's Community Care Access Centres, Kathleen would not receive enough care to keep her at home; she can afford to pay for what she needs.

Slumped in a chair beside her bed, Kathleen lets Dr. Mark take her blood pressure. "How is your breathing?" he asks.

"Short," she whispers.

He asks about the pain in her back and encourages her to take more Tylenol.

"It's a simple thing. If you under medicate yourself, you'll have more pain. You can take up to six Tylenol a day." He says her heart is "in good shape.

"Your chest is clear. You're better than you were one month ago. How's your energy?"

"She doesn't have any," Emily says.

"I was asking Kathleen," Dr. Mark says, firmly. "Keep trying to walk even if it's only two steps a day. Two steps become four, four steps become eight steps. If you work at trying to get from the bedroom to the bathroom, then maybe you can go downstairs. Would you like to go downstairs?"

"Of course I would."

NEXT UP, DORA, 91. The widow of a surgeon, she lives in a big house in Forest Hill.

"How are you?" Dr. Mark touches her gently.

"Things could be better," she croaks, cracking a grin. "I was

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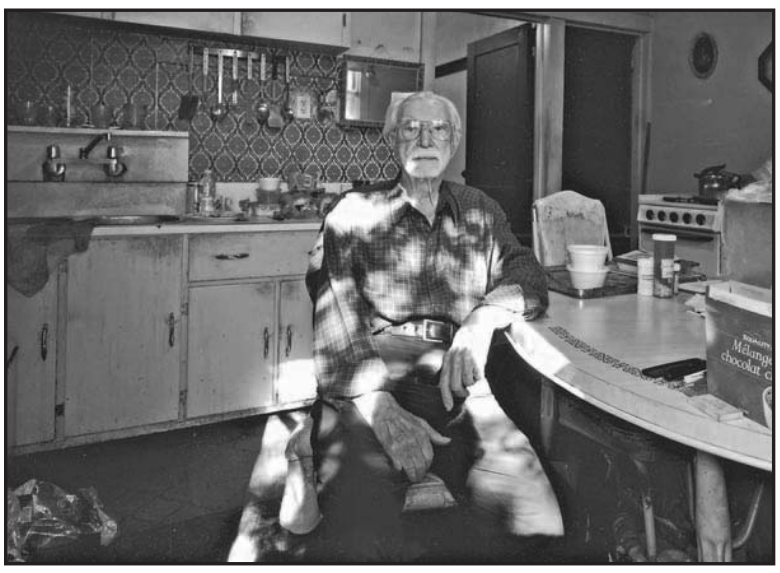
DR. MARK NOWACZYNSKI PHOTOS

Dr. Mark Nowaczynski checks on his patient John, a Korean War vet in his 80s who has become a recluse. His small apartment near Yonge and Eglinton is cluttered and his fridge is nearly empty.

'I thank God every night for Dr. Mark'



Clarence, 91, seen in his sun-dappled kitchen, is frail but refuses a walker. "I creep around," says the former oil company executive.

dreaming, so vivid, now it's gone. Sir, what are we going to do today?"

He checks her blood pressure, her heart, her breathing.

"I guess I've been lucky to get to 91. I'd like to be luckier. I sleep a lot. No energy. What future is there?"

"Nobody knows," Dr. Mark says.

"Nobody cares, " Dora says.

"You have three loving children," Dr. Mark says. "The end is near."

"WHAT THE SYSTEM NEEDS is not necessarily more doctors but doctors who do a little of this work, making house calls," Dr. Mark tells me in the car. "When I take residents (young doctors) out on rounds with me, they find it very satisfying. You learn so much about people, seeing them in their homes. The residents are amazed that old people can be so frail yet still living at home, until the end."

It may be a satisfying calling, but not financially so. "I'm paid twice as much for a house call as a family physician is for an office visit, but they see at least four patients in the time it takes me to do one house call."

We drop in on Elizabeth, 80, who is at risk for developing diabetes, has shortness of breath and fluid retention. Dr. Mark tells her that as she starts walking around more, she could stave off diabetes.

"I want to be independent," Elizabeth says adamantly. "Nursing home? No way. You've got to have a purpose. If you don't, you're a vegetable."

Dr. Mark checks her blood pressure. "Beautiful. Good. You're doing well." He checks her heart. "Your heart rate is down, that's good. The beta blockers are working. I'll be back in two weeks to take blood and check your kidney function. I don't anticipate problems."

"I thank God every night for Dr. Mark," says Elizabeth. "Don't let me upset him."

THORNCLIFFE PARK is next, to see a new patient. Theresa is 98, bed-bound, hasn't seen a doctor for two years. "Her daughter has been a heroic caregiver," Dr. Mark says.

The patient sits mutely in an armchair in the living room, feet up, head dropped, chin to chest. Her daughter explains that Theresa had her first mini-stroke in 1987, followed by many more strokes, and stopped speaking 18 months ago. "It's hard to believe this is my very active and social mother, sitting in the dark, head down. I wouldn't wish this on anyone."

They discuss medications. "I've been doing her meds for 11 years," the daughter says, going over a long list of different drugs. She pays five different caregivers to look after her mother; she brings in a dental hygienist to clean her teeth, a podiatrist to do her feet. "She gets 14 hours of care from the CCAC, six days a week. That's the maximum."

Dr. Mark holds Theresa's hand. He gets no response. "Theresa, I'm the doctor," he says. "Can I check your blood pressure?"

'It's an awful day. Can you give me something to relax me?'

The daughter is clearly overwhelmed. "I brought in the home care because of the loneliness. My mother sitting here all the time alone, I can't bear it.

"When you're in your 80s, friends don't drop by. They can't get out, or they're dead....

"She doesn't want to be in a nursing home. She said last fall, 'I would like to die.' She has severe osteoporosis. She broke her hip. She's been in diapers for a year. I can't change her diapers. I'm sorry, I can't do it. How much longer can this go on?"

"You'd be amazed," says Dr. Mark.

LAST STOP. Vera, 97, has pneumonia. She is dying, and has refused treatment. She lives in a Toronto Community Housing building.

Dr. Mark knocks on her door. She is lying in bed, in the dark.

"Miss Vera," he says. "It's Dr. Mark." He sits by her bed, holds her hand.

"I told you not to come," she mutters.

"It's my job to keep an eye on you."

"I'm not up to it."

"Do you want me to go?"

"No."

"Are you having trouble breathing?"

"It's an awful day. Can you give me something to relax me?"

"Do you want a patch?"

He means a narcotic patch, given to those close to death to quell pain and anxiety. "It would help calm you down."

She knows the meaning of the patch. "No! I don't want the patch!"

He gives her a glass of water, a tranquilizer and sleeping pill.

"Turn off the noise," she says.

"That's you making the noise, you're grunting and groaning when you breathe. The patch would help."

"No."

FOR MOST of his patients, "If I didn't go to them, they wouldn't get any health care because they can't come to me. They would fall through the cracks. These are hidden worlds: people who almost cease to exist, who have no voice.

"You're not looking at an exotic species in another world," he says. "You're looking at your future."

Portraits of aging: Henny Legg

Kingston resident Henny Legg, 93, is in good health and offers this simple formula to living a long life: "Hard work" and "lots of friends."

She bends, touches her toes: 'Can you do this?'

"I been really lucky, no pain, no arthritis," says Henny Legg, 93, flexing her fingers, "and my mind is still there." She laughs.

Legg laughs a lot. "Henny Penny," she says. "I'm a Dutchie."

She came to Canada in 1955, at the age of 40, with her husband and three children. The youngest, Gesina Laird Buchanan, 63, is with us today.

Legg lives alone in a one-bedroom apartment in Kingston. She is active and cheerful, with no complaints. What's her secret to a long and healthy life? "Hard work."

A meticulous housewife - her pristine apartment is evidence of her skills - she cleaned houses as a way to earn money and learn English. She had good clients - "a colonel, a doctor, a professor" - and she enjoyed people. Still does. Loves going out. Plays bingo practically every day.

"How many times did you go out to the bingo this week?" Buchanan asks.

BERNARD WEIL/TORONTO STAR

Henny plays Bingo almost every day.

"Let's see, I went on Saturday two times, afternoon and evening. I went on Sunday afternoon. Bingo on Monday and Tuesday. I won $75 on Tuesday. This afternoon (Wednesday), I go to play cards. Irene is coming to pick me up."

Buchanan explains with a laugh: "When her old friends die, she makes new friends who are younger than her, who can drive her to the bingo."

"I got lots of friends," Legg says.

"She's got good social skills, " Buchanan says. "She remembers people. When I take her grocery shopping, she'll see people in the aisles - 'I remember you from bowling. How's your sister?' - and she's cheerful."

Except a few weeks ago. What happened?

"She won $1,200 at the bingo and she took me out to dinner at Red Lobster and pigged out on shrimp and got sick," Buchanan says.

Henny Legg laughs.

"The shrimp were so greasy."

How does she feel about living alone? "I don't like it. It's lonesome, especially in winter."

But that's not the whole story. Buchanan points out that her own daughter, Linda, moved in to help her grandmother and then Legg "kicked her out" - moved into a smaller apartment and announced that Linda would have to find her own place. Linda now works as a recreational therapist at a nursing home, where Legg says she'll move if she has to. She doesn't fear it.

Above the sofa is a large, framed needlepoint, headlined "Nederland," with the names Henny and Bets stitched in the centre. "Bets was my best friend for 45 years. She died." Legg lists other friends: one developed dementia, another moved to a nursing home and didn't go out any more....

She stopped bowling, but she won the shuffleboard trophy two years ago. Legg stands up and bends over, touching her toes. "Can you do this?"

"Oh, Mother. She's such a show-off."

Has she ever had a serious illness? "I had breast cancer twice, two different kinds, and colon cancer." Legg shrugs. "I had skin cancer. I have a very good doctor. I think people die from cancer if they don't catch it early enough."

She looks at the clock. It's 10: 45 a.m. Legg says Irene will pick her up in five minutes to go and play cards. "And there's a strawberry social."

We hurry out, down in the elevator. The front door is open and Irene is waiting. Legg smiles and waves like the Queen, settling in to the front passenger seat as she is driven off.

The longest life

Jeanne Calment of France.

In the 100,000 or so years of our species' existence, our average life span has been about 30 years.

In the last 200 years, we eliminated the wild animals that preyed on us, discovered the importance of cleanliness, especially the benefits of washing our hands, and controlled childhood diseases through vaccinations. It has all helped increase our lifespan so dramatically that it's virtually doubled in the last century, from mid-40s to roughly 80.

The maximum human lifespan is 122, achieved by Jeanne Calment, who lived in the south of France all her life and ate a healthy Mediterranean diet.

Born in Arles in 1875, Calment died near Montpelier in 1997. She took up fencing at 85; she continued to ride her bicycle until she was 100, she enjoyed wine, and lived on her own (her husband had died many years earlier) until she was 110. She attributed her longevity to olive oil, which she poured on her food and rubbed into her skin.

After her death, her brain autopsy showed that she had the brain of a healthy 80-year-old. No dementia.

In Paris, I interviewed the famous French geriatrician, Dr. Bernard Forette. He was proud to say he had met Calment twice. "She was a wonderful woman."

Forette says that , "the impact of demographics and increased longevity presents us with a big problem."

"It is obvious that the proportion of elderly people is increasing dramatically. There will be more people living to be 100 years old. They will not all be as healthy as Mme. Calment."

BY THE NUMBERS

30 - 50
Percentage of people over 85 with some form of dementia

520,610
Number of people over 85 in Canada in 2006 census

13.7
Record percentage of Canadians 65 and older in 2006. Meanwhile, proportion of those under 15 fell to record low of 17.7 per cent

117
Age of oldest Canadian, Marie Louise Febronie Meilleur, who died in 1998.

122
Age of oldest recorded person in the world, Jeanne Calment of France, who died in 1997.

Sources: Statistics Canada

Facing end of the road the hardest part of living

Culture hasn't caught up with the immense gift of our extended longevity.

I am haunted by the eyes of the old people. I see their faces - the hundreds of old women and men I've talked to during the course of the past year - and I am filled with emotion, touched by their courage in growing old, in revealing their vulnerability and yearning for life.

How does it feel to know that what was undone is left undone? No time to go back. It may be one of the hardest things we ever have to do - to face our mortality, to recognize the end of the road, looming ahead - and the bravest thing is to continue to live. That's lesson one: Keep on living.

Bonnie Sherr Klein, grooving through the Vancouver Art Gallery cafe on her scooter, said that "disability teaches you to live with interdependence and not feel shame about dependence. Disability is a head start on aging; you learn to accept the vulnerability that comes with aging." Lesson two: Interdependency is necessary.

I started off looking at aging from the outside, not getting it, not understanding that I was looking into my own future. We are looking at where we will be, if we live long enough to grow old.

As a culture, we haven't expanded our vision to imagine the next stage, the third age - the gift of our extraordinarily expanding longevity - which could bankrupt the health care system if we don't make dramatic changes. We are the lucky ones. As a generation, aging baby boomers are carrying on into a whole new stage of activity that the culture hasn't caught up to yet. We are the healthiest, wealthiest, longest-lived bunch of oldies ever seen on the face of the earth.

In Victoria, B.C., where I started this journey last September, I was caught up in a world of seniors' social activism, Raging Grannies, "retired" executives volunteering to help non-profits, and Canadian grandmothers supporting Stephen Lewis's African grandmothers. Vibrant and engaged, these "retirees" find meaning and purpose in life by connecting with others. Lesson three: Volunteer, get involved, take on a cause. There's power in numbers, and god knows we've got the numbers.

At the end, it comes down to love and kindness, which is where life begins

JUDY STEED

Aging is part of a lifespan continuum and can't be examined in isolation. Poor children living in substandard housing, with inadequate nutrition and medical care, grow into less healthy adults and elders. Stress plays a huge part in sickness. Lesson four: We must do more to enhance people's lives, starting with affordable, supportive housing.

I carry with me the great models from Sweden and Denmark, where I experienced the beauty of social organization and elder care that puts elders first. I didn't know there could be lightness of being in a dementia home, where frail elders plant tomatoes and peel potatoes.

At Lotte, a rambling, shambling nursing home in Copenhagen, sleeping pills are not given. If you're 88 and wake up in the middle of the night and can't sleep, you can have a schnapps - or three. The pleasure principle. Everyone deserves to have attainable goals, said a Swedish nurse; if you can do up three buttons, we'll work with you to do up four buttons.

The Swedes and the Danes inspired me with their gift of caring - child care, free university, excellent care for seniors. They have determinedly put "user influence," as the Swedes put it, at the heart of their elder care and they have built societies that express kindness in their institutions. How incredible is that? Kindness as the major response to vulnerability. Kindness constructed through intense policy developments that put into practice the oft-heard, rarely achieved mantra, "patient-centred care."

At the end, it comes down to love and kindness, which is where life begins. The tenderness we show children and elders - these are ultimately the measures by which we are judged.

To learn to accept our vulnerability; to know there's no "recovery." This is who we will become. This is who we already are. "They" are us; we are them. Help each other.

10 innovative fixes for what ails us

Beth Cada, who learned the French horn in retirement.

Judy Steed's public policy recommendations to solve problems plaguing the current system:

1. PROBLEM: In Canada, "bed blockers" - older people stuck in hospital, ready for discharge, lacking the home support they require - occupy 5,000 hospital beds and consume $200 million annually. They clog emergency departments and expand wait times for others.

SOLUTION: Hospitals in Denmark eliminated bed blockers by creating a stiff incentive to get elders moving. Municipalities are required to pay for those who stay in hospital past discharge dates. That got communities working to move seniors on - to rehab or home care.

In Canada, even hospitals agree that community care is the answer. "I'm CEO of the Ontario Hospital Association and we think the solution is in the community," says Tom Closson, the former CEO of the University Health Network. An effective long-term home care system is the answer, he says - only then will seniors discharged from hospitals and nursing homes be diverted from emergency departments.

2. PROBLEM: There are 216 geriatricians in Canada - most not working in their speciality full time - serving a population of 4.3 million seniors. That's a ratio of 0.00005: 1.

There are 10 times as many pediatricians - 2,247 - serving a population slice (children) that's roughly the same size.

SOLUTION: There are four options: One, provide family doctors with more geriatric training. Two, set up Seniors Wellness Clinics at all hospitals, with geriatric specialists doing full assessments of medications, nutrition, exercise. Three, increase student grants to encourage more students to enter the field. Four, increase pay for geriatricians.

The Ontario government announced a raise earlier this fall which geriatricians hail as a positive step, but at $330,000 a year, they are still paid less than other high-profile specialties.

3. PROBLEM: Overmedication. At least $1 billion is spent annually on drugs seniors should not take, according to Dr. Michael Rachlis.

The World Health Organization estimates that 50 per cent of prescriptions are not needed and may be harmful - amounting to $8 billion a year of wasteful, possibly dangerous spending in Canada.

SOLUTION: Doctors should have access to an electronic prescribing system to monitor prescriptions.

An electronic model has been adopted by most Toronto hospitals, and should be available across Canada.

Roy Romanow's 2002 recommendation to create a National Drug Agency should be acted upon. It would assess the safety, quality and cost-effectiveness of new drugs, negotiate pricing, and develop a national program to monitor prescriptions and adverse drug reactions among seniors. To avoid creating more bureaucracy, the new agency would extract related monitoring functions from Health Canada and other agencies - improving efficiencies and saving money.

Sy**lvia Ostry, who recently started reading up on the Ottoman empire.**

Mae Lewis, who loves a good Harlequin romance.

J.C. Sharda on life: Keep breathing.

That's the easy part. The more challenging solution, and in ways most necessary, is cultural. In Scandinavia, seniors take fewer drugs and are more physically active. Canadian doctors should prescribe less and encourage more healthy behaviour.

4. PROBLEM: Deterioration of mind and body. Too often, seniors internalize ageism, stop doing things, and fall apart, mentally and physically, faster than necessary. Family members sometimes take over and do things for elderly relatives, instead of encouraging them to be active.

SOLUTION: Health promotion and public education, with a discussion of tax incentives to promote positive behaviour. "Physical inactivity is a proven risk factor for all-cause mortality and for various chronic diseases including heart disease, diabetes, osteoporosis, colon cancer and breast cancer," says Donald Paterson, professor at the school of kinesiology, University of Western Ontario. In moderately fit individuals, "these risks decrease by 30-60 per cent. Fitness is critical in preventing or delaying the onset of chronic diseases of aging ... In an aging society, the health benefits of greater population fitness would have an immense economic and societal benefit."

Focus on getting sedentary older adults to exercise programs led by volunteer fitness instructors in community centres. Reward seniors for participating with incentives/coupons.

Promote brain fitness. Encourage family doctors to check brain function and refer patients to brain health programs (like the ones at Baycrest), which should be available across the country.

If we can delay the onset of Alzheimer's disease by five years, we can reduce the incidence by half.

5. PROBLEM: One reason seniors flood emergency departments is their doctors don't make house calls - in part, because they are not financially viable.

SOLUTION: Double the house call rate - currently $40 for the home visit, $20 for travel time. A twofold increase would mean $80 for the home visit, $40 for travel time. A day in the hospital costs the provincial government from $800 to $1,200.

6. PROBLEM: Costly warehousing of seniors at $43,000 per person per year in long-term care facilities that are regulated to death; patient-centred care is rhetoric, not reality.

Too often, residents in nursing homes having nothing to do.

SOLUTION: Transform the culture of nursing homes to enable seniors to participate in meaningful ways, make decisions and have a glass of wine with meals. In Swedish and Danish nursing homes, the focus is on what frail elders *can* do: peel potatoes, weed the garden, sweep the floor. But we will never match Scandinavian spending on nursing homes - about double what it costs in Ontario - which underlines the importance of housing seniors with supportive services in the community.

The future is in home care. The federal government should establish a national home care program, co-determining national standards and cost-sharing arrangements with the provinces. Over time, the entire health care system can be re-engineered to shift resources from more expensive hospital-based care to home care and community agencies.

Create a Seniors' Innovative Housing Group, to help seniors form clusters, share space and services, reduce housing costs and waiting lists, and improve quality of life. Dr. Robert Bell, president of Toronto's University Health Network, has called for "a supportive housing approach that actually brings together people who need similar resources so we can provide them in an effective, efficient way."

Provide tax incentives and facilitators to enable older homeowners to rent out rooms to fellow seniors. The Brits have been doing this for years, making the solution more efficient by providing on-site "wardens" to supervise medium-sized locations, often doing double duty as cooks and handymen.

7. PROBLEM: So many acronyms, so little time. There are a handful of truly groundbreaking programs for seniors - read the profiles of some of our favourites at thestar.com/atkinson2008. But there's no national framework for transferring knowledge of our best innovations.

SOLUTION: Create an Elder Care Innovations Inventory led by Larry Chambers, president and chief scientist at the Elisabeth Bruyere Research Institute in Ottawa, and by Margaret MacAdam, a top Toronto gerontologist with encyclopaedic knowledge, to gather "best practices" and innovations in elder care, and make them available across the country. We'll save money and improve seniors' lives.

8. PROBLEM: The major cause of admittance to nursing homes is lack of help for housekeeping and groundskeeping. Seniors who can't keep up at home often move reluctantly into long-term care.

SOLUTION: The Veterans Independence Program (VIP) provides housekeeping and groundskeeping as long as veterans need it. At an average cost of $2,000-$3,000 a year, it's always more cost-effective than the alternative - institutionalization. VIP allows seniors to choose their own workers; VIP pays the bills.

Expand this program to non-veterans, add a volunteer component and you've got your answer.

9. PROBLEM: Isolation, depression, boredom, no one to talk to.

SOLUTION: Peer counsellors. Train volunteers and offer peer counselling for seniors at community agencies, nursing homes, Seniors Wellness Clinics.

"Peer counsellors don't tell people what to do," says Goldie Carlow, a counsellor from Victoria and a senior. "We ask: 'How would you like your life to be? Is this what you want?' She helps people realize they have choices. "It's up to you."

Also, promote lifelong learning.

The Seniors' College of Prince Edward Island has grown in 10 years from a membership of 45 to 527. Members pay $120 a year and take as many courses as they wish.

"It is a concept of peer learning that has grown around the world to provide opportunities for those who are 50 plus," says president Ian Scott.

"We use university and community facilities that we the taxpayers have built. When we get people on campus (at the University of Prince Edward Island) and using the facilities, they begin to realize that they are part of the campus community. It is an empowering process."

10. PROBLEM: Experts estimate that at least 10 per cent of seniors - a figure that's considered a low estimate - are subjected to abuse and have nowhere to turn.

SOLUTION: Require the mandatory reporting of abuse of older adults (just as it's required for the abuse of children) and provide more safe havens like Toronto's Pat's Place, where seniors can, with support, stabilize their lives.

Program contact information:

This list reflects a sampling of excellent programs available to seniors:

• Abbeyfield Houses Society of Canada, operates 29 group homes for seniors across Canada, ***416-920-7483***.

• Advocacy Centre for the Elderly, a legal aid clinic for low income seniors, ***416-598-2656***.

• Baycrest, ***www.baycrest.org***, brain health and Memory Link program information can be found here.

• Cardiovascular Health Awareness Program: to become a volunteer, learn about the risk factors associated with high blood pressure, or to find out if CHAP is in your community monitoring blood pressure, go to ***www.chapprogram.ca***.

• Community Care Access Centres (CCAC), Ontario's purveyors of home care, can be reached at ***www.ccac-ont.ca***. For the Toronto Central CCAC, call ***416-506-9888***.

• Dixon Hall, a multi-service community agency in Toronto, can be reached at www.dixonhall.org, click on the supportive housing project. Email to ***info@dixonhall.org***, call ***416-863-0499***.

• Elder Abuse: If you need help, if you're worried that a senior is being exploited or abused, call Family Service Toronto at ***416-595-9618***. ***www.familyservicetoronto.org***

• Falls Prevention Program, at Toronto Western Hospital, 399 Bathurst St., ***416-603-6769***.

• Mid-Toronto Community Services, to volunteer or find out about programs, www.midtoronto.com, email ***admin@midtoronto.com*** or phone ***416-962-9449***.

• Older Women's Network: to reach the network, email ***info@olderwomensnetwork.org***, phone ***416-777-9543*** or go to ***olderwomensnetwork.org***.

• Pal Place, offering rent-geared-to-income and market rents in co-op housing for people who've spent most of their lives in the performing arts, ***www.paltoronto.org***.

• St. Christopher House, ***www.stchrishouse.org***, ***info@stchrishouse.org***. It has multiple locations and two supportive housing sites. Phone ***416-504-3535***.

• Seniors Health Research Transfer Network (SHRTN): to find out about SHRTN's communities of practice and knowledge brokers, go to ***shrtn.on.ca*** or ***ehealthOntario.ca***; look down on the left and you'll see a box for SHRTN. You can phone ***1-877-227-6432***. Its library service is at ***1-866-393-4877***. Email to ***info@shrtn.on.ca***. Deirdre Luesby, executive director, is at ***613-562-6262*** x***1654***.

• Seniors Wellness Clinic at Toronto Western Hospital, 399 Bathurst St., ***www.uhn.ca***, ***416-603-6769***.

• TeleHealth Ontario, ***1-866-797-0000***, for all health related questions.

• Yee Hong Centre for Geriatric Care, ***www.yeehong.com***, email ***centre@yeehong.com***, phone ***416-321-6333***.

Acknowledgements:

This project is a massive team effort and credit belongs to everyone who helped me along the way.

I'm in awe of the people who care for elders in Ontario, the love and compassion that infuses their work. This journey began at Baycrest with Stephen Herbert, the former CEO whose team built Baycrest into a world leader in geriatric care and research. I felt his deep caring for elders. Through Herbert, I met Dr. Michael Gordon, Baycrest's geriatrician, who is not shy about his love for his grandmother and for his elderly patients. Herbert directed me to Margaret MacAdam, the brilliant gerontologist who travelled with me to Denmark, whose knowledge and insights guided me throughout. She pointed me in the direction of Larry Chambers, the chief scientist and CEO of Elisabeth Bruyère Research Institute, an inspiring innovator; and Dr. Bill Dalziel, the greatest advocate for geriatricians in the world. Back at Baycrest, Kelly Connelly kept on answering questions and pinpointing information with exquisite accuracy and patience.

Susan Morgan, the chaplain for St. Elizabeth Health Care, taught me about compassion. She visits people in their homes and guides them out of the darkness of depression, or helps them face death. Her work is informed by Jean Vanier, the founder of L'Arche, where developmentally challenged people are loved and cared for and treated as if they're gifted. Not *as if*, Vanier would say; they *are* gifted and they share with us with the gift of their humanity, their vulnerability. That's what old people do, as well.

Once this project moved from the field and into the office, my team at the Toronto Star kicked in. Alison Uncles supervised the Atkinson project and guided me with unerring judgment and brilliant insight.

The Star dispatched two of the paper's best photographers, Bernard Weil and René Johnston, to document the series. Weil and Johnston are used to big, challenging assignments. Would they be sensitive to my elders? The results - still photography in the newspaper pages, and video on thestar.com - are heartbreaking in their beauty. Such artistry! I had tears in my eyes when I saw the images, which capture with exquisite sensitivity the joy and frailty of old age.

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May many more follow us.

Judy Steed

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