CASE EXAMPLE

Leon Coles is 70. He is African American. Mr. Coles worked all his life until he had a stroke. His jobs varied, but he always earned just a little more than the minimum wage. As a result, he receives minimal Social Security benefits. The stroke has severely limited his mobility. Mr. Coles lives with his wife, Louise; their daughter; and three teenage grandchildren. Louise Coles is in relatively good health and spends most of her time caring for Leon. The daughter works full-time as a legal secretary. Her salary feeds and clothes the family, but there is nothing left for her father's long-term health care needs. The family is just hanging on.

CASE EXAMPLE

Emilia Gonzalez is 85 years old and lives alone. She speaks little English. Her husband, who is deceased, was a migrant farm worker most of his life and never received Social Security or had other pension coverage. Mrs. Gonzalez also worked in farm fields and was exposed to harmful pesticides. She has been diagnosed with uterine cancer, which was advanced by the time she could get access to a doctor. The prognosis is poor. Mrs. Gonzalez has no monetary resources; she relies on Medicaid to pay for her health care.

Although more women than men are in the young-old, old-old, and oldest-old age categories, they have only recently been included in research and political dialogue. The 1981 White House Conference on Aging was the first forum to address the concerns of women who are older and to look at breast cancer, osteoporosis, and the effects of hormone replacement therapy. The long-term effects of gender discrimination are not yet fully understood. In a society that celebrates women for their beauty and their ability to give birth, little value is placed on older women. Being female and being older can combine to cause challenges for women in terms of mental health issues, including rendering them invisible in the mental health system or being seen as mental health problems (Fawcett & Reynolds, 2009).

The major sources of income for people who are older include Social Security, Supplemental Security Income (SSI), income from property and other assets, public and private pensions, earnings, and public assistance. In large part because of the social security safety net, the majority of older people have adequate income and the extent of poverty is lower than among the rest of the population. Table 8.2 identifies the percentage of various groups of people who live in poverty.

Gerontological social workers need to advocate for services located in the racial or ethnic communities of people who are older. These services should be culturally appropriate; for example, nutrition programs should use local foods. It is preferable for the social worker and the staff to be bicultural or bilingual. Communities that are predominantly Latino should have pertinent

Table 8.2 Percentage of Older People Who Live in Poverty—2015

Asian and Pacific Islander	14.7%
Latino	18.1%
Indigenous People	45.0%
African American	19.2%
White	7.8%

Source: U. S. Census Bureau, 2016.

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social service and elder care information in Spanish as well as in English. All communities should be encouraged to determine how to deliver services so that they best fit the needs of residents. Outreach services are particularly critical to ensure delivery and implementation of social services for older people in nondominant communities.

Values and Ethical Issues LO 5

Gerontological social workers encounter difficult professional situations that have profound ethical aspects. Among the most difficult is the question of whether physician-assisted suicide is carefully controlled compassion for patients with painful, terminal illnesses or physician-initiated murder.

Dr. Jack Kevorkian of Michigan was well known for his efforts in the area of physician-assisted suicide. Prior to 1998, Dr. Kevorkian participated only in **passive euthanasia**, the intentional termination of one's own life with means provided by another person, such as a doctor. In other words, the patient commits suicide by taking a lethal dose of medication or using some other means obtained from another person. Dr. Kevorkian was arrested two times for providing means of death in cases of passive euthanasia.

Kevorkian's third arrest took place in 1998, and it concerned a case of **active euthanasia**. In such cases, the doctor actually administers the lethal injection or actively causes death in some other manner. Kevorkian injected a lethal dose of drugs into a patient with Lou Gehrig's disease. He was convicted of second-degree murder and of delivering a controlled substance without a license, and was sentenced to 10 to 25 years in prison. His appeal and request for a new trial were denied by the Michigan Court of Appeals in November 2001. He was released from jail in June 2007.

Active euthanasia is outlawed by the federal government. However, assisted suicide has received significant support. The majority (68%) of the US public favors permitting doctors to assist in the suicide of terminally ill patients (Dugan, 2015). However, only five states—California, Montana, Oregon, Vermont, and Washington—and the District of Columbia have legalized physician-assisted suicide. Oregon voters approved the Death with Dignity Act in 1994 and reaffirmed it in 1997 (60% of voters supported it). Washington passed its Death with Dignity Act in 2008. In 2009, state courts ruled it legal in Montana, and in 2013 Vermont passed end-of-life choices