

## Ethics and Aging

### Increased Longevity Creates Opportunities for Catholic Health Care

David Sulmasy's book *The Rebirth of the Clinic*<sup>1</sup> was an eye-opener for me. It helped me see how the scientific revolution and the Enlightenment shaped our understanding of medicine and healing as primarily scientific undertakings. The original clinic, Sulmasy argues, conceived medicine, dying and death in quantitative and analytical terms. It gave rise to the "clinical gaze" which rendered the patient an object of observation rather than a subject in need of caring. My impression from reading Sulmasy was that this trend led to the emergence of modern medicine in the late 18<sup>th</sup> and early 19<sup>th</sup> centuries.

Sulmasy is correct that the modern disciplines of medicine and medical education took shape after 1850. However, another book, *Growing Old in Christ*,<sup>2</sup> helped me see that roots of this view of medicine, aging and death went back much further. The essays in this book describe aging in the biblical, patristic, medieval and modern periods. They show that the tension between scientific and religious views of sickness began long before the birth of the clinic.

The earliest example is the great literary work *Piers Plowman*, which was written between 1360 and 1380. The author, William Langland, sees the traditional view of aging and death as a spiritual experience rooted in the death and resurrection of Christ and in Christian community, as jeopardized by economic

changes. As a result, says David Aers, "human life and the traditional virtues are transformed to sustained communities in which markets, market values, and individual profit are paramount goods and the church is assimilated to the practices and values of this world."<sup>3</sup> Old age, he says, began to be viewed through a "secularized medical tradition" which valued medical remedies that can drive away death."<sup>4</sup> [I am sorry to say that at least in Langland's view, the mendicant friars, who have been described as an adaptation to the market economy of the Middle Ages, played a significant role in promoting this view].

This emerging view is reflected in the work of Franciscan Roger Bacon (d. 1290), who was a brilliant polymath, an empiricist and a very early proponent of what we would now call the scientific method. It is hard to imagine his precocious work *De Retardatione Accidentum Senectutis* coming from a time when so few life-saving interventions were available. It was based on the conviction that old age and even death could be delayed. Even then, this created fears that "medicyns for the body" threatened to replace known spiritual remedies.<sup>5</sup> It would be a long time till Bacon's views blossomed into the clinic that Sulmasy describes, but they contained the seeds of our present attitudes to death and dying.

Modern market theory and capitalist economics were developing at the same time, and they too had their effect. David Shuman notes three things that changed our attitudes about death: a) the

biomedicalization of death; b) the hegemony exerted by our capitalist economy; and c) the gradual erosion of our communities including ecclesial communities that sustained the more traditional view of aging and death. These factors created an analytical and economic approach to life in which the elderly were seen as quantities factored into an equation.<sup>6</sup> This tendency to see health care in strictly economic terms persists to this day as we see the most contentious arguments about health care reform revolve around “how much will it cost?” and “who will pay for it?”

Another influence may have been Protestant Evangelicalism, which has its roots in the early Enlightenment period. One writer says a new view emerged from the dominant Protestant culture that was shaped by “perfectionism in physical and spiritual matters and belief in the power of the individual will, [which led them to] dichotomize and rationalize experience in order to control it.”<sup>7</sup>

Happily, contemporary movements toward hospice and palliative care have begun to reverse some of our stunted thinking about aging and death. However, even these two important movements risk compromise unless we in Catholic health take care to imbue them with spirituality and an ethical framework that is grounded in our Resurrection destiny and Eucharistic hope. Such a grounding will balance out the excessively technical and economic paradigms that have shaped medicine thus far. Let me cite several things that I think must inform our ethics of aging.

### 1.) Create space for theology. D.

Stephen Long is correct when he says that theology has ceded its rightful place

to economics in such a way that it views economics as a “Technical science like auto mechanics, gall bladder surgery or housing construction...because these are neutral, technical disciplines we need not relate theology to them, nor should they encroach on theological language.”<sup>8</sup> It is true, as we often say, that there is no “such thing as a Catholic appendectomy”, but this does not mean that sound technique is the end of the story. These techniques, indeed all of the aspects of Catholic health care, must be shaped by our understanding of the person as essentially spiritual and the care that we deliver as having a transcendent dimension.<sup>9</sup> This is particularly true when we are dealing with aging and death, which are stubbornly mysterious and not fully comprehensible to us in this life. Death is not just a biological or clinical event.

**2.) Find ways to restore aging to community.** Sickness and death are very solitary experiences – no one can feel exactly what we feel. Still, no one should die alone. Each of us has to find the meaning of death, but we can’t do it alone. We need the help of others. Ethicist Daniel Callahan says, “We cannot find the meaning in death entirely on our own, even if this seems to be the demand placed on us. We need the help of others, of a community whose meaning we can share, making it our own with the same strength as if we discovered it ourselves...”<sup>10</sup> This is a huge challenge if what John Milbank says is true: Our capitalist system “in its most innate tendency precludes community. This is because...it makes the prime purpose of society as a whole and also of individuals to be one of accumulation of abstract wealth or of power-to-do things in general, and rigorously subordinates any

desire to do anything concrete in particular, including the formation of social relationships.”<sup>11</sup>

This means strengthening the bonds of friendship for the elderly, many of whom complain about loneliness and isolation. Hauerwas and Yordy go so far as to say that “we must be taught to die through friendship.”<sup>12</sup> This learning starts with retirement, which usually signals a time when we leave the world of economically-productive work. It is important to remember that we may be leaving a job, but not our vocation, and our vocation includes eventual death. But what is the vocation of an older person who may no longer have income-producing work (and so does not fit into the economic equation), but who still has a call to the Christian life? What pulls the elderly retired person into the future, and to the completion of her vocation if there are no promotions, or raises, or successful deals to complete? This is especially pertinent if the market has shaped us to see ourselves as “producers and consumers” which undercuts “the ways of life of those tradition-bearing communities with substantive commitments to particular accounts of the human goods.”<sup>13</sup>

**3.) Acknowledge the uniqueness of aging and dying.** Aging may be a universal experience, but we do not all age and die in the same way.<sup>14</sup> This is simply a variation on the fundamental Catholic theological principle “grace perfects nature.” Grace does not come in one size only, it is custom-made for each of us so that it matches our personalities, dispositions, intellects and vocations. Were it otherwise, all the saints would look alike. In fact, the saints were all holy, but they achieved that holiness in a myriad of ways each of which was

completed by a particular form of grace. So too, as we age, grace perfects us in different ways. Part of clinical and pastoral care must involve discovering the specific ways in which the grace of aging and dying is given to this specific person.

**4.) Cultivate the virtues of aging.** Health care ethics, perhaps like health care in general, has tended toward the episodic. Mostly we deal with “ethical questions” which often revolve around crisis situations. This is markedly true with end-of-life care, where we focus on “doing” rather than “being.” Charles Pinches suggests in his essay that we need to help the elderly develop the virtues appropriate to aging. He names simplicity, delight, empathy, courage [note that he says there is no private courage, which takes us back to the importance of community], truthful remembrance and hope as starters, but there are many more that we could name and cultivate. These virtues are necessary for those of us who are aging, but they are also necessary to the young, who may learn from our example.<sup>15</sup> Cultivating and sharing these virtues may be the most distinctive aspect of our vocations as we age.

## Conclusion

The rapid rise of longevity and the hegemony of scientific and market paradigms of medicine create a unique opportunity to see aging as more than an economic, social or clinical problem to be fixed. As we deal with the real ethical challenges that aging brings, we must see them through the lens of a graced period of life that is, as much as youth and middle age, a gift from God.

C.B.

<sup>1</sup> *The Rebirth of the Clinic: An Introduction to Spirituality in Health Care*. Washington: Georgetown, 2006.

<sup>2</sup> Stanley Hauerwas, Carole Bailey Stoneking, Keith Meador and David Cloutier, eds. Grand Rapids: Eerdmans (2003).

<sup>3</sup> "The Christian Practice of Growing Old in the Middle Ages," *Growing Old in Christ*, 38-62, at 55

<sup>4</sup> Aers, 56.

<sup>5</sup> Aers, 56.

<sup>6</sup> "The Last Gift: The Elderly, the Church and the Gift of a Good Death," in *Growing Old*, 151-169, at 153-54.

<sup>7</sup> Carole Bailey Stoneking, "Modernity: The Social Construction of Aging," in *Growing Old*, 63-90 at 71; see also 78 on connection with "liberal capitalist values"; and excessive dependence on the Word, which led to diminishment of symbol and ritual, which prior to the Reformation had helped provide meaning for aging and death.

<sup>8</sup> "The Language of Death: Theology and Economics in Conflict", in *Growing Old*, 129-150, at 139.

<sup>9</sup> Another dimension of this is to understand Catholic health care as sacramental. See Clarke Cochran, "Renewing the Sacramental," *Health Progress* (November-December 2003) 12-15.

<sup>10</sup> *The Troubled Dream of Life: In Search of a Peaceful Death* (New York: Simon and Schuster, Touchstone, 1993) 223.

<sup>11</sup> Joel Shuman quoting John Milbank in "The Last Gift" in *Growing Old*, 158.

<sup>12</sup> Stanley Hauerwas and Laura Yordy, "Captured in Time: Friendship and Aging," in *Growing Old*, 169-185, at 183.

<sup>13</sup> Shuman, "The Last Gift," in *Growing Old*, 159.

<sup>14</sup> Patricia Beattie Jung, "Differences Among the Elderly: Who is on the Road to Bremen?" in *Growing Old*, 112-129, at 112.

<sup>15</sup> See Pinches, "The Virtues of Aging," *Growing Old*, p. 212. He says the virtuous elderly can "teach us in this to live, and delight in what is now present."

## Advance Directives & Dementia

On March 30, 2018, Kaiser Health News published an article titled "Aggressive New Advanced Directive Would Let Dementia Patients Refuse Food."

Such a headline quickly made the rounds through the CHA offices, and many members forwarded the article for our attention. At first glance, one might view this title as regarding artificial nutrition and hydration using tube feeding - a topic discussed many times in this quarterly.<sup>1</sup> However, the article details a different and more troubling option. In filling out this directive, a patient can agree with the statement, "My instructions are that I do NOT want to be fed by hand even if I appear to cooperate in being fed by opening my mouth." The group proposing this new advanced directive is End of Life Choices New York, which

claims that the directive "aims to provide patients a way to hasten death in late-stage dementia, if they choose." "Hasten death" is the key phrase in the ethical assessment of this document. The *Ethical and Religious Directives* specifically prohibit actions whose intent is to hasten death.<sup>2</sup> I do not want, however, to focus my entire conversation on why this document is illicit and contradictory to Catholic moral teaching.

Instead, I believe we are once again witnessing a continued push within our culture for the elimination of the dying process. Looking at the motivation behind this document, we only need to listen to the words of its author who argues that patients with dementia "do not want their dying prolonged." Society has in some ways accepted death as the

ultimate outcome. Yet, the days, weeks, or months at the end of life have become an obstacle to be overcome. Death is no longer the fear. *Dying* is the object to be avoided at all costs.

The new effort in New York stems from the same underlying norms and beliefs held within our broader society concerning this stage of life. We see echoes of it in the physician assisted suicide debates where control over dying is framed as a personal choice. In some ways, this document falsely upholds this hegemonic view of autonomy within the medical field. In others, it merely reaffirms what we have witnessed in the past decade regarding care at end of life; society and the family should not bear any burden from the patient. Pope Emeritus Benedict XVI named this very problem in a 2007 address to the International Congress of the Pontifical Council for Health Pastoral Care. He identified that “today’s efficiency mentality often tends to marginalize our suffering brothers and sisters, as if they were only a ‘weight’ and a ‘problem’ for society.”<sup>3</sup> Such marginalization forgets the inherent dignity of the person and places the comfort of others above the one suffering.

Many of you know the Church’s historic *ars moriendi* tradition. One other exemplar of a “good death” is St. Therese of Lisieux. St. Therese’s final years were plagued by illness, that many now believe to be tuberculosis. She connected her final days with the image of a spiritual journey: “Yes, I’m like a tired and harassed traveler, who reaches the end of his journey and falls over. Yes, but I’ll be falling into God’s arms!”<sup>4</sup> This imagery of a journey continues in our tradition and was a favorite of Benedict

XVI who proclaimed that death “is a passage toward the embrace of the Heavenly Father, full of tenderness and mercy.”<sup>5</sup> How then do we help society share this beautiful imagery?<sup>9</sup> Are we too late to overcome this rising sentiment towards a “hastened” death?

I wish to echo Fr. Charlie’s concluding point in his article, while substituting one key word: we now have the unique opportunity to see *dying* as more than an economic, social, or clinical problem to be fixed. This renewed focus by society on dying ought to spur Catholic health care’s efforts in increasing palliative medicine and hospice care. Access to these services gives patients more authentic autonomy and provides greater dignity and comfort during their last days. This effort of expansion is advocated by major health systems, the United States Conference of Catholic Bishops<sup>6</sup>, and the Pontifical Academy of Life. The latter two groups are championing for collaboration between different ministries of the Church to approach this challenge across the globe.<sup>7</sup> The challenge that faces our efforts is great, but not insurmountable. The reframing of this stage as a truly important step in our life and in the life of those whom we love will take even more exemplars to show the way. It will attack what is at the root of the problem, not fear of death, but rather fear of dying. The Catholic Church’s rich tradition of providing comfort and care for the dying provides a compelling path forward for a new vision of human dignity and death.

N.B.H.

<sup>1</sup> An overview of this ethical concern was published in 2016 in an HCEUSA article by Fr. Myles Sheehan S.J. titled “Feeding Tubes in Advanced Dementia and Ischemic Stroke.”

<sup>2</sup> *Ethical and Religious Directives*, #61.

<sup>3</sup> Pope Benedict XVI, “Address of His Holiness Benedict XVI to Participants in the 22nd International Congress of the Pontifical Council for Health Pastoral Care.” Nov. 17, 2007

<sup>4</sup> *The Way of the Cross with the Carmelite Saints*, (ICS Publications:2013).

<sup>5</sup> Pope Benedict XVI, “Address of His Holiness Benedict XVI to Participants in the 22nd International Congress of the Pontifical Council for Health Pastoral Care.” Nov. 17, 2007

<sup>6</sup> Secretariat of Pro-Life Activities, “Physician-Assisted Suicide: Threat to Improved Palliative Care,” April 3, 2017. [http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/suicide\\_palliative\\_care-2.pdf](http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/suicide_palliative_care-2.pdf)  
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