STATEMENT DE425

Ethics at the Twilight of Life
Our Obligation To The Elderly

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SUMMARY
The fastest growing population in developed nations is the elderly, those age 65 and older. This growth ensures that issues affecting seniors will continue to take center stage in the political arena. Far beyond mere politics, however, this "graying of society" will result in the increasing frequency of chronic diseases, which itself will pose challenges to the institutions of family and marriage. Due to both biological and cultural factors, women will likely continue to bear the brunt of caregiving. Thus women and adult children will increasingly face troubling and often tragic decisions as they care for elderly family members. Due to the large amount of information available and due to Christian resources for elder care, however, such difficult choices will be opportunities to demonstrate the true meaning of love.

As the devaluation of human life in Western culture continues to accelerate, and American states debate and even approve the legalization of euthanasia, Christians need to grapple with the responsibilities involved in a serious pro-life ethic. One such responsibility concerns our obligation to demonstrate Christian love to the elderly. Most people know that statistics can be misleading. Nearly everyone has heard the old story about the statistician who drowned in a river whose average depth was only three feet! But some statistics and their self-evident meaning are so startling that they seem to jump right off the page. Such is the case when one looks at our aging society and at the problems and issues that it brings.[1]

Did you know that:

- Some 20 percent of *all* people who have *ever* lived past age 65 are alive *now*![2]

- In 1860, half the population of the United States was *under age* 20, and the vast majority of the population was not expected to live to age 65.[3]

- From 1990 to 1996, the number of Americans 65 or older increased *elevenfold* (from 3.1 million to 33.9 million). The overall percentage of the population 65 and older increased from 4.1 to 12.8[4]

- In 1940, just 7 percent of those age 65 would survive to age 90; by 2050, the number will climb to an astonishing 42 percent![5]

- In just 30 years, the number of people in the United States over 65 will more than double to reach 70 *million* people![6] Such growth means that nearly 1 in 5 Americans will fit this category, up from 1 in 100 in 1900.[7]

The significance of our aging population goes far beyond seeing more gray hair in the supermarket checkout lines. Elderly people often fall prey to chronic diseases that, more often than not, don't kill outright, but leave the sufferers with pain, difficulty in performing routine tasks, and in need of health care that calls for both increased dollars and specialized personnel. As our society becomes more "gray," who will foot the increasing medical bills for the elderly? Furthermore, such longevity has steadily increased the gap between retirement and death. Designed for a time when death followed quickly on the heels of leaving one's job, will Social Security be there for future generations?

Beyond monetary concerns, our aging world demands that society's leaders focus on this burgeoning segment of our population. What are its needs and desires as it enters its twilight years? How can younger members of society help the elderly live productive and rich lives? The situation of the present writer is a case in point, underscoring the personal nature of these common family dilemmas.

BEYOND COLD STATISTICS

I am a baby boomer who has two surviving parents living far across the country. In significant ways they and I fit the patterns so typical in modern society. As a mobile "boomer," I took advantage of a better teaching position far away from home. My stepfather, a World War II veteran, is older than my mother and a frequent patient of both the local hospital and nearby outpatient clinics. My mother cannot leave home for long periods of time, fearing that my stepfather may fall or suffer a debilitating accident. This scenario raises profoundly troubling issues for our family.

First, as the "oldest son," I feel responsible for the well-being of my parents. After all, who gave me Band-Aids for my childhood cuts and scrapes, who fed me when I was hungry, and who always assured me "everything will be all right"?

At times, however, it seems as though I'm caught up on some sort of "career ladder' that has somehow pitted my interest against the needs of my parents. When we have family discussions about the different levels of health care available for my stepfather, every choice seems fraught with perils, and nobody wants to be the one to bring up the issue of checking him into a nursing home. That recourse seems terribly isolated and final. In addition, I think both my mother and I feel that such a choice is somehow a dereliction of duty. She as wife and I as son want to "do the right thing" — but what *is* it?

As previously mentioned, my stepfather's chronic health problems — so typical for men his age — ensure that my mother has a limited social and personal life. As the primary caregiver, she leaves the house only for short trips to the store or other errands. Long trips and vacations are rare, and they need thorough, long-range planning in order to be accomplished. I'm afraid that her caring for my stepfather is wearing her out and will weaken her own health. How can women like my mother address the pressing and very intimate issues that come with caring for a chronically ill spouse? Are there no options other than a complete physical breakdown due to overwork or the neglect of one's marriage partner?

As is common in men who not only went through the Great Depression but also fought a world war, my stepfather has an independent streak. He deplores the thought that he has become "a burden" to my mother. His mind is alert and sharp, but his body is weak and frail. Are there health care options that can preserve some semblance of his independence while, at the same time, treat his medical condition?

As is now obvious, this situation raises a whole host of moral issues, especially for Christians. As members of the body of Christ, what are our responsibilities toward our loved ones as they age? We know that we owe respect and honor toward our elders, but does that mean putting our own lives on hold, waiting for them either to recover or die? Let's first discuss how the Bible speaks about elder care in general and then move toward specific issues concerning spousal and filial care.

THE BIBLE AND THE ELDERLY

The Bible is consistent and clear in its message about those who are least able to fend for themselves. In the Old Testament, God mentions widows and orphans among those who should be singled out for special care and protection (Exod. 22:22; Deut. 27:19). Jesus continues this pattern of divine care by heaping scorn on those who would go so far as to foreclose on widows' homes (Matt. 23:14). James even says that caring for widows and orphans are the premier fruits of true worship of God (James 1:27).

Similarly, God reserves special wrath for people who would take advantage of either the blind or deaf, making their well-being a matter of justice (Exod. 19:14–15: Deut. 27:18–19); that is, we *owe* justice to the widow, orphan, and those who may be disadvantaged in our society. Since it is clear from even the most cursory reading of the Scriptures that God desires justice *for all* people, His special mention of it in this context is evidently a warning to those who would take advantage of the weakest members in our society — those least likely to stand up for themselves.

Clearly, the elderly as a group would fit into this category. It is true that in recent years, various lobbying groups have served both to increase elderly visibility and to provide much-needed political clout. Nonetheless, decreasing

physical vigor and steady or declining income mean that the elderly will likely continue to be a vulnerable population. Christians and morally reflective people ought to fight against such a trend. Before dealing with the specific issues that come with caring for the elderly, let's examine how advancing age can affect marriage.

"IN SICKNESS AND IN HEALTH"

Many of those reading this article know firsthand the wrenching pain and tragic choices that chronic disease can inflict on a marriage. Marriage is one of the most cherished and important relationships in any society. Yet, when disease and/or debilitating old age strike couples, it forces people to examine just what duties and obligations come with the relationship. Christians must go one step further. They must bring in insights from Scripture and Christian tradition to combine with ethical reflection — all to determine, if possible, what marriage requires in terms of caregiving.

First, it is no surprise to acknowledge that women bear the brunt of caregiving far more than men. "All told, two of every three family caregivers to the elderly are women."[8] This is partly due to biological factors and partly to cultural pressures. Biologically, women simply live longer than men. In 1996, there were 120 women for every 100 men, aged 65-69 years. For persons aged 85 and older, the ratio becomes even more pronounced, with 257 women for every 100 men.[9]

There are also cultural and societal influences that help perpetuate women as the primary caregivers. And, when men assume the caregiving role, they are more likely to take on less personal chores such as home repair and gardening, with female caregivers taking on the feeding, toileting, and bathing of the disabled spouse.[10] Such gender roles nonwithstanding, it is clear that an ethical analysis of marriage is needed to give sharper focus to spousal responsibilities in caring for elderly spouses.

Nancy Jecker finds two basic models of marriage that exist in contemporary society.[11] The first we'll label the "relational" model of marriage. Here, the stress is on the personal relationship formed in marriage, and as the relationship formed in marriage, and as the relationship goes, so goes the marriage. If such a relationship is unlikely or impossible due to poor health, the marriage itself is weakened accordingly. Clearly, this stress on relationship doesn't capture the full-bodied essence of marriage given to us in Scripture. The Bible consistently calls for a higher level of spousal commitment, insistent on *agape* (unselfish, unconditional love) as the marital norm.[12]

Jecker's second model might be labeled the "commitment" model of marriage. Here, the theme is commitment to one's spouse, and such commitment trumps any notion of marriage as purely and solely a romantic attachment. In this model of commitment, "marriage might be thought of as a spiritual union, in which two individuals are literally joined, and a new entity is created."[13] In this new entity, this union, the commitment is not some theoretical committing of one's self, but commitment to a particular person.[14] Clearly, this model has close and meaningful affinities to the Christian understanding of marriage. What then can it tell us about duties and limits of care?

Surely marriage partners have a reasonable expectation of receiving care from their spouses in their old age. Marriage is a voluntary covenant before God and man and places certain obligations on each partner that are expected and proper. Beyond mere obligation, love and care enter into the marriage relationship, enhancing and even going beyond mere duty in determining the extent to which one will go to care for the other. Love "seeks not its own" and looks for the best possible means to cherish one's beloved. Even here, however, there must be limits.

Just as our finite resources and time place limits on what we can do in terms of social good, so also are there limits even within the bounds of Christian marriage regarding what may be required of a spouse. It is not inconsistent with Christian ethics to agree with Jecker when she says, "Marital responsibility ends where responsibilities have become impossible to meet or where competing obligations or virtues take precedence."[15]

In considering whether it's time to relinquish caregiving to professionals, it is important to consider the situation of the caregiver herself or himself. It is well documented that caregivers of spouses (compared to noncaregivers of the same age) suffer more depressive disorders and have triple the incidence of stress symptoms, nearly double the use of medications, reduced immune function, and increased health problems.[16] These risks are quite real and must be a part of the equation when deciding whether to employ various levels of professional help. It is certainly not "Christian" to insist that someone must care for his or her spouse if such care is reasonably seen to lead to the financial ruin or wrecked health of the caregiver. Decisions for such involved caregiving can be entered into only with serious (and personal) deliberation and prayer.

"Honor your father and mother" — which is the first commandment with a promise — "that it may go well with you and that you may enjoy long life on the earth" (Eph. 6:2–3).

The justice that God requires for our treatment of the elderly ripens into love as we look at how the New Testament deals with our treatment of our parents.[17] Paul's reiterating of the commandment to honor our parents is linked with the apostle's observation that "this is the first commandment with a promise." This is not cast in some sort of utilitarian context that we honor them *in order* to receive something, but it is a positive command indicating that blessings often accompany proper behavior. Honoring parents is so important to Paul that, like James (regarding widows and orphans), he says those who neglect their immediate family (including parents) have "denied the faith" and are "worse than an unbeliever" (1 Tim. 5:8). We should not be surprised at his severity. Jesus had already said that all the commandments could be summarized into two — loving God with all of one's heart, soul, and mind and loving one's neighbor as oneself (Mark 12:28–31; Luke 10:27–28). If this neighbor-love (*agape)* is to be shown even to strangers (as demonstrated by the parable of the Good Samaritan), how much more should it be a consistent demonstration to those who have nurtured us all our lives?

Honoring and loving our parents thus represent two sides of the same coin. The Greek word used for honor (*timê)* focuses on the office or station of the person due honor;[18] that is, we should honor our parents because of their place in our lives and their position in relation to us. The biblical idea of *agape*, on the other hand, expresses that idea that we should love people *regardless* of station or position. This is the love that loves purely for the sake of the person being loved; it is the self-sacrificial love that puts the needs of others first.

As those who wish to be faithful to the biblical witness, how then should we care for our elderly parents? Scripture portrays our duties to parents and the elderly as a target with concentric rings, the immediate family occupying the "bulls-eye" and hence our highest priority, with others occupying more distant rings of the target, receiving less — but very real — attention (e.g., 1 Tim. 5:1–8). Clearly, Paul's scorn for those who would not even provide for their family indicates God's highest priority: people first should care for their families before worrying about matters of general social concern.

As my situation indicated, children often feel a strong pull to care for their parents. Such intuitive feelings are legitimate, and they point to what Sarah Vaughan Brakman sees as the twin sources of filial responsibility in caregiving: reciprocity and gratitude.[19] Reciprocity (which corresponds roughly to the biblical concepts of giving justice and honor to parents and the elderly) means giving to people what is due them. Gratitude goes beyond reciprocity in its insistence on benevolence, and it has some affinities with the biblical idea of love.

In most ethical analyses, gratitude is seen as the proper source and motivation for adult children caring for their elderly parents. Reciprocity is like justice, in that its obligations are satisfied by giving to another what he or she is owed. Thus, "Once a duty of reciprocity is met or discharged, the relationship based on reciprocity…ends."[20] Actions based on gratitude, however, often serve to extend and deepen an existing relationship. Clearly, an attitude of gratitude toward one's parents (assuming any semblance of a normal upbringing) is proper, and it has affinities with the biblical mandates for caring for parents. Yes, grateful children should make sure, as Paul says, "to provide" for their parents. And such provision clearly goes beyond food and shelter; it also includes basic medical needs.

When adult children take such an active interest in their parents' well-being, there are both drawbacks and benefits. It is not an easy thing to see fathers and mothers — pillars of strength to the caregiver as a child — slowly lose their strength and health. Not only is such a role reversal a strong reminder of one's own mortality, but it also brings feelings of protection to the fore. Nobody wants to see loved ones hurting.

Moreover, when one reads the accounts of sons and daughters who have rediscovered the depths of love that the filial bonds can bring, there are moments that can make it all worthwhile. Thus it is often true that when one cares for his or her parents out of love and gratitude, the relationship is often "furthered and enhanced."[21] Those academic words stand for broken relationships that have been healed; weak ones that have been strengthened.

Yet even the most caring daughter or son can go only so far. There often comes a time when the burden of care "simply becomes too much." Whether it's conflicting obligations of virtue or the parent's health simply needs more than laypeople can provide, there may come a time when it's proper to consider bringing in extra help. How does one know whether that threshold has been crossed? Like caring for a chronically ill spouse, the decision is usually a

balancing act that considers the unique features of each case. Nevertheless, there are general guidelines that can help potential caregivers.

WHEN IS IT TIME FOR THE PROFESSIONALS?

When deciding whether professional assistance is necessary, one usually measures the elderly patient's ability to perform the "activities of daily living" (ADL). These refer to the individual's ability to accomplish such essential and personal tasks as toileting, dressing, and bathing. Important, but not as critical as ADL, are the "instrumental activities of daily living" (IADL), such as shopping, meal preparation, and managing one's money.[22] Both sets of activities are assessed in evaluating an individual for professional assistance.

Individuals who cannot perform one ADL are considered "moderately disabled," and those who cannot perform two or more, "severely disabled."[23] Clearly, such people, if they are to live at home, need consistent help in routine activities. Moreover, because such activities often need regular attention *throughout* the day, one must plan carefully and realistically when considering caring for the individual. It is doubtful that a caregiver could maintain a traditional job when the elder cannot perform one or more ADL. It is important, however, to realize that there are many options in professional home health care — both outside and inside the home.

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LEVELS OF CARE

Not long ago, there were few choices for those considering professional health care for their elderly loved ones. All too often, the elderly progressed quickly from retirement to a chronic illness, to a nursing home, then to death. Well-meaning families seemed hemmed in by few options. No more. Beyond the advances in home health care, there are a plethora of choices available for elder care, each dependent on the level of independence enjoyed by the individual.[24] The least involved level is called Independent Living and requires that elders be mobile and able to care for themselves. Examples of this level of care include senior apartments, subsidized housing, a shared elder home, or renting out a room in exchange for help with household chores.[25] In general, there is no on-site health care for this category — seniors often choose this option for the greater level of companionship it provides.

The next level of care is semidependent living, and this level may provide meals, health care, and organized activities that are designed expressly for the special needs of elders. To be eligible for this level, a resident must not require 24-hour care or skilled nursing. Here, because the elder is more vulnerable, it is appropriate for family or loved ones to take a more active role in the decision-making process.

The last level, dependent living, includes nursing homes and extended care facilities. Here all levels of ADL/IADL are provided for, and prospective residents usually require 24-hour skilled nursing care. At this level, families and loved ones must be involved in the decision-making process, not to override the decision of the elder, but to insure that he or she receives the best care possible. To fulfill such duties, it is incumbent on all parties to make informed decisions — obtaining all relevant information from the institutions in question.

Besides the many options available for elder care outside the home, there are increasing levels of care available inside the home. In less than 10 years, "high-tech home care has emerged from near total obscurity to become the fastest-growing sector of the entire health care economy."[26] Many different types of cases may be appropriate candidates for home health care, from the acute crisis to the chronic disease. Here again, however, there are drawbacks as well as benefits. It is well known that the home environment can be a strong component to healing, but "caring for a family member or close friend on high-tech home care can be extremely demanding."[27] Besides looking out for the usual duties of toileting, bathing, and the like, caregivers must often become familiar with complicated equipment, and such additional responsibilities can add unbelievable amounts of stress. To alleviate such stress, other family members, friends, or church members ought to help with the caregiving. Some HMO's even cover such "respite care" when done by professionals.

Of course, a home environment may be the best place of all for that most private and personal of moments — the death of a loved one. As well, the hospice movement has tried to emulate the home environment in its emphasis on informality and care.[28]
Not every case, however, is the same. There are instances in which dying patients actually prefer the impersonality of the hospital. In addition, the home setting offers less control for potential abuses, and resources for emergencies,

than does the more sterile hospital or hospice. In any regard, caregivers must know the needs and wishes of the elder — that's where preventive ethics come in.

PREVENTIVE ETHICS

The number one rule to follow — both for the caregiver and the recipient — is to "keep informed." There is an amazing amount of information on elder care available, from types and levels of care to rules and regulations that govern the nursing home industry. Much of the growth in information is due to the Internet explosion and the ability to get information from the Worldwide Web.[29] By accessing such resources everyone should be able to find the information they need.

Second, elders dependent in any significant way (respecting either ADL or IADL) need an advocate who has no vested interest in the health care system. When an elderly person is ill, the balance of power and authority is nearly all in favor of the health care professional.[30] Being sick can be quite frightening to anyone, let alone a dependent older person, who needs someone he or she can trust will be on his or her side. To meet this need, a whole new job has been invented: the professional Geriatric Care Manager. But the well-informed family member can also act in this capacity. When in this role, advocates must make sure that they are acting for the elder in his or her best interests. Unless there is clear evidence that the elder's decision-making capacity is seriously impaired, the advocate's position is to ensure that the elder's wishes are followed.

Third, an advocate must strive to bring into the decision-making process all those family members who have real moral ties to the elder. While engaged in this process, it is important to openly discuss in the presence of the elder values of care and how different options of treatment may or may not enhance those values.[31] Not only will such discussion of values help in assessing the elder's decision-making capacity, but it also will help ensure that the elder knows that he or she is not alone.

THE TESTIMONY OF LOVE

According to sociologist Peter Berger, every worldview or institution requires a social foundation that renders it believable. Such a foundation is called a "plausibility structure."[32] This structure speaks not so much to cold logic as it does to our intuitive selves. For example, although it may be logically possible that a certain religion is true even though its adherents are known for their obnoxious behavior, it is nonetheless certain that such behavior tends to render the religion less *plausible.* We frankly doubt that eternal truth would come in such unattractive packaging.

As societies age, the opportunities for loving our elders provide obvious plausibility structures for the Christian faith. It is certainly not the case that only Christians are capable of loving the elderly; it is just as *true*, however, that a properly lived-out Christian ethics of elder care makes the faith attractive and credible. And in a world so starved for demonstration that such love is even *possible*, such an accomplishment is indeed a worthy goal.

Notes

[1]Most figures and statistics address the United States' population, but this 'graying of society" applies equally to the populations of most developed nations.
[2]Resources in Social Gerontology, "Social Gerontology and the Aging Revolution,"1. Find at www.trinity.edu/~mkearl/geron.html.
[3]U.S. Bureau of the Census. Current Population Reports. Special Studies, 23–190, *65+ in the United States* (Washington, D.C.: U.S. Government Printing Office, 1996), 2:1.
[4]Profile of Older Americans: 1997, 2. Found at http://www.aoa.dhhs.gov/aoa/stats/profile.
[5]U.S. Bureau of the Census, *65+ in the United States,* 3–4.
[6]Profile of Older Americans, 3.
[7]U.S. Bureau of the Census, Current Population Reports, Special Studies, 23–190, 65+ in the U.S., Government Printing Office, 1996, 1. Find at www. Trinity.edu/~mkearl/over65.jpg.
[8]Nancy Jecker, "What Do Husbands and Wives Owe Each Other?" *Long-Term Care Decisions: Ethical and Conceptual Dimensions,* Laurence B. McCullough and Nancy L. Wilson, eds. (Baltimore: Johns Hopkins Press, 1995), 174.
[9]Profile of Older Americans, 2.
[10]Ibid. Also see Sarah Vaughan Brakman, "Filial Responsibility and Long-Term Care Decision Making," in the same volume, 181–82.
[11]The following discussion comes from Jecker, 157–65.

[12]For example, see Genesis 2:24 and Jesus' interpretation of it in Matthew 19:5ff. Also see Paul's emphatic defining and strengthening of the marriage bond in Ephesians 5:22–25.
[13]Jecker, 163.
[14]Ibid., 164.
[15]Ibid., 167.
[16]Ibid., 169.
[17]Although most New Testament verses deal explicitly with parents, it is clear from the context that they include all elderly in their admonition to love and honor. It would be absurd to make the distinction that only *my* parents deserve such care — for one thing, most elderly are somebody's parent! This general "ethics of elder care" is in strong continuity with the attitudes expressed in the Old Testament, which based such special care on a reduced ability to care for one's self.
[18]See Volume 2 of *The New International Dictionary of New Testament Theology,* Colin Brown, ed. (Grand Rapids: Zondervan, 1976), 48ff.
[19]Unless otherwise noted, the following discussion interacts with her article "Filial Responsibility and Long-Term Care Decision Making," in *Long-Term Care Decisions.*
[20]Ibid., 186.
[21]Ibid., 187.
[22]Nancy L. Wilson, "Long-Term Care in the United States," in *Long-Term Care Decisions, 37.*
[23]Ibid., 38–39.
[24]The following categories come from "Types of Care," in Global Careguide, 1996, found by request at care@careguide.net.
[25]Families should obviously exercise caution in choosing people to share living arrangements with their elders.
[26]John D. Arras, *Bringing the Hospital Home* (Baltimore: Johns Hopkins Press., 1995), xiii-xiv.
[27]Ibid., 6.
[28]See William Ruddick, "Transforming Homes and Hospitals," in Arras, 175.
[29]By simply asking their computers to search the Web for "elder care" sites, searchers will be amazed at the considerable amount of information available.
[30]Laurence McCullough, Nancy Wilson, Jill Rhymes, and Thomas Teasdale, "Managing the Conceptual and Ethical Dimensions of Long-Term Care Decision Making: A Preventive Ethics Approach," in *Long Term Care Decisions*, 226.
[31]Ibid., 234.
[32]Peter Berger, *The Sacred Canopy* (Garden City: Doubleday, 1969), 45.