JUST HEALTH CARE FOR AGED AUSTRALIANS: A ROMAN CATHOLIC PERSPECTIVE

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TABLE OF CONTENTS

Abstract ii

Declaration iii

Acknowledgments iv

Introduction 1

PART I THE AUSTRALIAN SCENE AND PROBLEMATIC ISSUES

Chapter 1 Aged Care Policies in Australia 11

Chapter 2 Problematic Questions: Humanistic Reflection 59

PART II ETHICAL RESPONSE: RECENT BIOETHICAL ANALYSIS

Chapter 3 The Context of the Bioethical Debate 119

Chapter 4 Two Proponents of Just Health Care 175

Chapter 5 Two Proposals for Just Health Care for the Aged 231

PART III ETHICAL RESPONSE: THE CONTRIBUTION OF ROMAN CATHOLIC MORAL THEORY

Chapter 6 The Relevance of Roman Catholic Moral Theory 267

Chapter 7 Problematic Questions: Theological Reflection 335

Chapter 8 Just Health Care for the Aged: Three Concepts 405

Chapter 9 Just Health Care for the Aged: Two Resolutions 461

PART IV CONCLUSIONS, IMPLICATIONS, PROPOSALS

Chapter 10 Just Health Care for Aged Australians 477

Bibliography 493

ABSTRACT

Just Health Care for Aged Australians: a Roman Catholic Perspective provides a philosophical and theological analysis of health care for aged persons. It explores the ways in which Roman Catholic moral theory might contribute to the development of just health care for aged Australians.

The thesis is divided into four parts. Part I surveys aged care policies in Australia until 1992 (chapter 1). This provides the context for the philosophical and theological analyses that follow. In light of defects present in Australian aged care, chapter 2 offers a humanistic reflection on three problematic questions concerned with the meaning of aging, well-being and care.

Part II is a bioethical analysis of just health care for aged persons. The context outlined in chapter 3 provides sufficient background to appreciate the contribution of two American bioethicists who have published extensively on the topic. Chapter 4 presents the liberal approach of Norman Daniels and the communitarian perspective of Daniel Callahan. Chapter 5 criticises their thinking in reference to two justice questions: the policy proposal of an age criterion for health care delivery and the nature and scope of the obligations adult children have to care for aged parents (the so called intergenerational obligations question).

The form of the theological analysis in Part III mirrors the form of the bioethical analysis in Part II. Having established, in chapter 6, the relevance of Roman Catholic moral theory for the inquiry, chapter 7 revisits the three meaning questions studied earlier and frames them within a number of theological givens which effectively transform their meaning. Chapter 8 then sets out three key theological notions central to Roman Catholic thinking: the human person, the common good and justice as preferential option for the poor. These provide the key for developing the theological conclusions of chapter 9 in reference to the two justice questions of the age criterion proposal and the question of intergenerational obligations.

Part IV brings together the philosophical and theological analyses of Parts II and III and presents a number of conclusions, implications and proposals relevant to just health care for aged Australians.

DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

November 8, 1997

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Special thanks are due to my uncle, Revd. Dr. Thomas Connolly, to Dr. Richard Wade, Sr. Margaret Press RSJ, Fr. Maurice Shinnick and Fr. Anthony Mannix who went far beyond the call of duty and friendship to read a final draft of this thesis.

INTRODUCTION

This thesis provides a philosophical and theological analysis of health care for aged persons. It explores the ways in which Roman Catholic moral theory might contribute to the development of just health care for aged Australians.

The thesis aims to do five things. First, it provides a philosophical analysis of aging and aged care that outlines and criticises liberal and communitarian approaches to health care for the aged. The contributions of two leading proponents of just health care for the aged in the English speaking world are the focus of study. Norman Daniels represents a liberal approach and Daniel Callahan a communitarian perspective. Their analyses of American health care in an era of limits specify two questions of justice: the policy proposal for an age criterion in distributing health care to the elderly; and the broader philosophical issue as to the nature and scope of the obligation adult children have to care for their aging parents.

Second, the thesis offers a systematic theological analysis of health care for the aged from the point of view of Roman Catholic moral theology and medical ethics.

Third, it relates these philosophical and theological considerations to just health care for the aged. Two assumptions underpin this task. It is assumed that Roman Catholic moral theory in the post-Vatican II era proposes a Christian humanism in dialogue with the contemporary world. Further it is assumed that contemporary bioethics has relied increasingly on analytical philosophy and has been dominated by the preoccupations of liberal democratic societies, especially that of the United States. These assumptions influence the structure of the thesis on two levels. Humanistic reflection is able to be integrated within a theological framework and the insights of Roman Catholic systematic theology can be directly related to contemporary bioethical analysis.

Fourth, the thesis analyses two justice questions relating to health care for aged Australians and does this in light of the philosophical and theological studies undertaken.

Fifth, this study indicates a number of implications for health care for aged persons that arise from the philosophical and theological inquiry undertaken. Proposals for the further development of just health care policies for aged Australians are also presented.

Rationale

I undertook this study in light of a number of significant gaps in current scholarship. There has been a dearth of detailed philosophical analysis of aging and being elderly in the English speaking world. What literature there is in this field is influenced by the two philosophical perspectives current in the intellectual and political spheres of the English speaking world, namely liberalism and communitarianism. A similar gap is evident within Roman Catholic moral theology and medical ethics. To my knowledge there has been no detailed or systematic theological analysis of health care for the aged in recent times. The absence of an interdisciplinary philosophical and theological analysis of health care for the aged is likewise evident. In Australia, where the focus has been primarily directed to policy and health care delivery questions, the gaps in scholarship just mentioned have also been evident. The only significant philosophical and theological analyses occurring in Australian literature are to be found in reference to the "neon light" issues at the beginning and end of life, such as reproductive technology and euthanasia. Finally, it is important to note that that there has been little or no discussion of the ways that Roman Catholic moral theory might contribute to the development of just health care policies for aged Australians.

These important defects attain a greater significance when linked with the scale and effects of aging, both of individuals and populations, which contribute to a new set of problems and usher in a new era for first world societies such as Australia. The demographic reality of an increasing number and proportion of aging persons in Australian and other first world nations is further complicated by longer periods of good health and activity in early old age and the greater prevalence of one or more disabilities or illnesses, whether acute or chronic, in later old age. Increasing expenditure directed especially to the care of persons in the last few years of their lives is causing imbalances within society. In light of these and other changes aging, and health care for the aged, have moved from the margins to the mainstream of public concern and have entered into the policy priorities of Australian governments.

Equally significant for any study of aging are the experiences of individual aging persons in our society. Their identity, financial security and quality of life in the community throughout the years following their retirement from the workforce constitute a cluster of issues that shape aging as a new problem challenging Australians for the forseeable future.

As an integral part of Australian society the Roman Catholic Church must confront the reality and the consequences of individual and societal aging. During the 19th

century a commitment to Catholic education and health care were seen as important means for furthering the welfare and progress of Catholics in this country. As part of this process priority was given to constructing education, health and welfare institutions and to organising pastoral activity. In both areas the Church may be judged to have been successful. At the same time, however, discussion of a theology of aging in the Australian Church was almost non-existent. With a few exceptions in the area of health care the Catholic community has had negligible involvement in the development of national policies in health or aging. Recent rapid changes in the health care system together with a crisis of identity in Catholic health care in recent times have also muted the Church's voice.

The concerns and orientation of this thesis have arisen from my life and work in the Australian and Catholic community. The Australia I knew as a child after World War II was a nation of young people that rapidly expanded through an influx of European migrants. Because of this demographic transition the evolving social welfare and health care programs of the last fifty years have only belatedly turned their attention to issues of caring for an aging population. For eleven years from 1986 I was spokesman on medical-moral matters for the Roman Catholic archdiocese of Adelaide liaising with the media and parliament. Throughout this period attempts were made to introduce legislation into the state parliament legalising voluntary euthanasia. In opposing these moves it became obvious to me that more was required of our society and the Church if the momentum for euthanasia was to be reversed. It is imperative that public policy, health care and social services be developed with greater concern for the elderly and their quality of life. I am convinced that the type of care we offer to aging persons in Australia attests to the sort of society we are and wish to be. While engaged in the euthanasia issue I was a member of the South Australian Council on Reproductive Technology, a statutory body established by parliament to develop ethical codes governing the clinical and research aspects of reproductive technologies in the state. This task made me intensely aware of the difficulties that beset liberal democratic societies as they confront conflicts about fundamental values affecting the good of the community. The experience of working with a committee drawn from diverse backgrounds in the civil community impressed on me the importance of the Catholic Church's role in contributing to community consultation and public policy development, especially in the area of health care. Unless aged care is taken seriously in public discourse there is every likelihood that aged persons will become the new poor in Australian society. Already it is clear that a disproportionate percentage of this group will be women. As a member of a religious community founded by St. Vincent de Paul my vocational commitment is toward the marginalised and poor in our society. Taken together these lived

experiences have contributed greatly to the choice of topic as well as to the orientation and method adopted in this study.

Structure, Content and Argument of the Thesis

Two considerations of a methodological character must be noted at this point. First, the thesis is interdisciplinary in its scope. It explicitly crosses the boundaries between bioethics and social ethics and incorporates both philosophical and theological analyses. This inclusiveness points to a number of assumptions that pervade the work: (1) that bioethical discourse must be understood in the context of general ethical discourse; (2) that bioethical issues must necessarily be studied against a backdrop of wider social ethical concerns; (3) that the Christian humanism of Roman Catholic moral thinking must critically engage the values and movements of the contemporary world; (4) that the moral, religious and civil obligations of Roman Catholics in Australian society require them to contribute to the common good of our society especially through the development of just health care policies for aged persons.

As a result of its interdisciplinary character the argument of this thesis depends on a broad range of scholarly work. This is particularly the case in chapters 1, 3, and 6 which outline the Australian, the bioethical and the theological contexts essential for an appreciation of the ethical responses offered by bioethics and Roman Catholic moral theory. From among the large number of distributive justice questions that might have been examined in this study I have chosen to focus on two specific questions, and this for two reasons. First, the two bioethicists studied, Norman Daniels and Daniel Callahan, have explicitly and extensively addressed both the policy proposal that an age criterion be implemented in health care delivery and the wider question of intergenerational obligations especially in reference to adult children and their aging parents. Second, these two justice questions arise out of the experience of limits in a world of finite resources. In doing this they readily permit and require an exploration of justice at both policy and philosophical levels. In this way they contribute a richer texture to the analysis of distributive justice than is common in recent debates about rationing and the allocation of scarce resources. For this reason Daniels and Callahan have made an important contribution to recent bioethics by choosing to study these two specific justice questions in relation to health care delivery to the aged.

The second methodological consideration derives from the particularities of Australian history, society and health care which establish a context for the study

undertaken in this thesis. Since there is a dearth of detailed and systematic studies, both bioethical and theological, of Australian health care and the aged it has been necessary to develop the argumentation of this thesis using studies from other parts of the English speaking world, especially the United States of America. Australia continues to be influenced by its British roots in such areas as philosophy, government institutions and its national health care scheme. Since World War II the American influence and emphasis on the individual, technology, economics and commerce have become increasingly pervasive. Two things follow from this: first, careful scrutiny must be given to the ways in which British and American contributions have been absorbed and integrated into the Australian scene; second, critical attention must also be given to the underlying values and priorities operating in all three countries. Two examples illustrate my point. The social solidarity underpinning the National Health Scheme in the United Kingdom differs radically from the emphasis on the individual and personal freedom in the U.S. health system. Both Australia and America have Medicare programs. The Australian form operates as a national health scheme whereas, for the U.S.A., Medicare is directed to the elderly.

The thesis is divided into four parts: the Australian scene and problematic issues (Part I); recent bioethical analysis of just health care for the elderly (Part II); the contribution of Roman Catholic moral theory to the issue (Part III), and an exploration of the implications of this study for just health care for aged Australians (Part IV).

Part I has two chapters. Chapter 1 sets the scene for what follows by outlining aged care policies in Australia up until 1992. It indicates that little or no attention has been given in Australian literature and health care delivery programs to wider humanistic considerations that significantly affect just health care for the elderly. These issues are studied in chapter 2 through a detailed analysis of three questions: What does it mean to grow old? What does it mean to be healthy or ill? What does it mean to care? Answers to these questions enlarge and enrich our perceptions of the issues relating to health care for elderly persons.

Part II develops an ethical response to justice, health care and aging through an exploration of recent bioethical reflection. Chapter 3 commences at a general level by sketching different contexts within which the bioethical debate has occurred. In chapter 4 the contributions of two American bioethicists, Norman Daniels and Daniel Callahan, are outlined in detail sufficient to appreciate their thought on the two concrete justice questions studied in chapter 5. The two issues of an age criterion for

health care distribution and the nature and scope of intergenerational obligations gained importance in American bioethical reflection as a result of the experience of limitations in delivering health care to aged persons.

Part III presents an ethical response based on Roman Catholic moral theory. This part of the thesis revisits matters already explored historically and philosophically in the preceding two parts of the thesis. It mirrors the structure of the bioethical response in Part II by moving from a more general introductory chapter to a specific consideration of the two justice questions already considered. Chapter 6 seeks to establish the relevance of Roman Catholic theology, moral theory and medical ethics for the issues central to the thesis. Chapter 7 returns to a consideration of the problematic questions analysed from a humanistic perspective in chapter 2. Chapter 7 argues that the theological contribution of Roman Catholic moral theory frames the issues in a manner that transforms and enriches them with direct consequences for how we deliver health care for the elderly. In chapter 8 three central concepts in Catholic theological reflection are explored. There it is argued that the notions of the human person, the common good and justice as preferential option for the poor advance the earlier bioethical discussion of Part II in significant ways. These substantive concepts contribute to the elaboration of more adequate justice criteria relating to the question of age and the obligations that should exist between adult children and their aging parents. Chapter 9 proposes a theological response on the basis of chapters 6-8, rejecting the age criterion proposal and proposing a more adequate understanding of the nature and scope of intergenerational obligations in terms of the theological notion of *responsibility*.

The structure of Parts II and III of the thesis may be imagined in the shape of a funnel. Chapters 5 and 9 occupy a place, it might be said, at the narrow point of the funnel. The chapters that precede chapters 5 and 9 in Parts II and III move from the general contexts of chapters 3 and 6 through the substantive contributions of chapter 4 in bioethics and chapters 7 and 8 in Roman Catholic moral theory. The contributions of Norman Daniels and Daniel Callahan presented in chapter 4 exemplify two strands of philosophical and political thinking, Daniels the *atomist* perspective of liberalism and Callahan the *social* view of communitarianism. Part II aims to show how the two justice questions discussed in chapter 5 are analysed by two bioethicists representing the liberal and communitarian ways of thinking. The inadequacies of both philosophical approaches become evident as Part II unfolds. These are starkly portrayed in the responses they offer to the two justice questions, namely the policy proposal for an age criterion in health care distribution and the question of the nature and scope of intergenerational obligations. Because of these

inadequacies Part III critiques the material from the viewpoint of Roman Catholic moral theory.

In light of the extensive investigations of Parts II and III of the thesis, Part IV seeks to fulfil three objectives. First, it aims, through the contribution of Roman Catholic moral theory, to redefine the two justice questions of the age criterion proposal and the issue of intergenerational obligations. A more adequate set of justice criteria is proposed. Second, the detailed consideration of health care for aged persons from the perspectives of bioethics and Roman Catholic moral theory, allows me to sketch a number of implications that have the potential to enrich further consideration of health care for aged persons. Third, the re-appraisal of justice criteria for health care delivery and the implications of this study for health care for aged persons make it possible to put forward a number of proposals for Australian policies relating to justice and health care for elderly persons. Fufilment of these three objectives satisfies all the elements present in the title of this thesis: "Just Health Care for Aged Australians: a Roman Catholic Perspective".

PART I

THE AUSTRALIAN SCENE AND PROBLEMATIC ISSUES

Part I consists of two chapters. Chapter 1 provides a picture of aged care policies in Australia in sufficient detail for the bioethical and theological analyses of Parts II and III to be applied. The primary focus of the thesis is health care for aged Australians. In order to place this issue in context it is necessary to consider a number of issues which directly affect study of health care for the elderly such as demography and economic, housing and community service issues. All of these have influenced the policies and implementation of health care for aging Australians. These interconnecting elements contribute to a tapestry of aging policies that have evolved in Australia over a century. They provide the starting point for this study. The implications of the philosophical and theological responses are developed in Parts II and III and the whole apparatus is refracted back to the Australian scene in the conclusions of Part IV.

The discussion undertaken in chapter 2 is necessitated by certain characteristics of Australian health care for the elderly. The primarily reactive, technical and pragmatic nature of Australian aged care policies and health care delivery attests to a certain poverty in the quality of its theoretical reflection and indicates the narrowness of its functional concerns. The questions of meaning discussed in chapter 2 provide an opportunity to appreciate perspectives that are more broadly humanistic in tone and that have humanitarian implications. Chapter 2 thus provides a set of insights that link the concrete concerns of health care for aged Australians into the mainstream of Western thought.

CHAPTER 1

AGED CARE POLICIES IN AUSTRALIA

1.1 Aging: Some Introductory Comments 13

- 1.1.1 A Question of Definition 13
- 1.1.2 The Human Experience of Aging 15
- 1.1.3 Aging and Measurement 16

1.2 The Demography of Aging in Australia 16

- 1.2.1 The Present Situation 17
- 1.2.2 Future Projections 20
- 1.2.3 The Implications of an Aging Population 22

1.3 The Economics of Aging 27

- 1.3.1 Aging People, Work and Employment 27
- 1.3.2 Retirement Income 29

1.4 Housing Elderly Australians 34

- 1.4.1 The Domestic Needs of the Elderly 34
- 1.4.2 Types of Accommodation Used by Aging Persons 34
- 1.4.3 Issues Related to the Housing of the Aged Population 37

1.5 Health, Health Care and the Aged 38

- 1.5.1 Health and the Elderly 38
  - 1.5.1.1 The Social Dimension of Health 38
  - 1.5.1.2 Health, Illness and Aging 40
- 1.5.2 Health Care for the Aged 43
  - 1.5.2.1 Dimensions of Health Care 43
  - 1.5.2.2 Health Care Services, Funding and Policies 44
  - 1.5.2.3 Institutional Care for the Aged 46

1.6 Community Services and the Aged 48

- 1.6.1 Community Care: Its Evolution and Providers 48
- 1.6.2 Family Care of the Elderly 50
- 1.6.3 The Political Context of Community Care 51
- 1.6.4 The Home and Community Care Scheme and the Aged Care Reform Strategy 52

1.7 Summary and Conclusions 55

- 1.7.1 Summary 55
- 1.7.2 Conclusions 55
  - 1.7.2.1 The Elderly Person 55
  - 1.7.2.2 The Community of the Elderly Person 56
  - 1.7.2.3 Responding to Old Age in Australia 57

CHAPTER 1

AGED CARE POLICIES IN AUSTRALIA

This chapter provides a brief, synthetic account of the context in which aged care policy has evolved in Australia. This context of an aging Australia provides a backdrop for the arguments in moral reflection that are developed throughout the following eight chapters of the thesis, leading to a re-examination of this context in the final chapter. Chapter 1 relies on the work of established scholars in the field such as Kendig, McCallum, Howe and Rowland to map particular areas of the aged care landscape. At the same time due attention is paid to the historical context of the areas being studied.

The publication of Don Rowland's *Ageing in Australia* in 1991 and the House of Representatives Standing Committee for Long Term Strategies report *Expectations of Life: Increasing the Options for the 21st. Century* (1992) have been chosen as the cut-off point for this historical survey. The years 1991-1992 provide a suitable marker for the transition that has occurred in aged care policies in Australian public life. Prior to that time the policies of aged care and the delivery of care services were fragmented and on the margins of the political agenda in Australian public life. By the year 1991 aged care policies had entered the Australian policy main-stream and there is evidence as well that aged care services had become more coordinated by that time. This coordination was certainly intended by the policy makers.

Five areas have been chosen for consideration. Each has a direct reference to the elderly in Australia - demography, economics, housing, health and community care. These five perspectives enable one to take a comprehensive view of Australian society such that all the significant elements for constructing a view of aged policies are present. The five issues inter-connect sufficiently to provide a well textured view of Australian attitudes, policies and care services.

Australia is experiencing a demographic transition the significance of which is contentious. Some arguments emphasise the spectre of a blow-out in dependency ratios, demands placed on family members to care for elderly parents and relatives, the cost of pensions, health and community care to name a few. It is, therefore, imperative to have a clear idea of the facts available regarding the numbers, proportion and shifts in older cohorts. This will provide a sound basis for the ethical evaluations that must be made - as justice demands!

Equally important as demographic change is an understanding of post-retirement finance in areas such as superannuation and pensions. Aged care policies, if they are to be just and caring, require a texture of post-employment financing sufficient for the aging person to live with dignity and assured of a basic standard of living. As with the demographics, here too a correct understanding of the economic issues at stake is vital for an informed assessment of Australia's care of the aged. Closely related to the economics of aging is the issue of housing: it is commonly said that owning one's home is the key to economic sufficiency for aged Australians. Elderly persons have particular domestic needs that, if left unfullfilled, increase the burden on the wider community. Whether the aged person lives in his or her home, in rental accommodation, is a boarder or lodger, lives with their family or resides in a retirement village, the environment has a significant influence on the dignity, morale and quality of life of the aged person. When physical movement is inhibited by increasing age, suitable housing assumes increasing importance in the daily events of living.

A primary concern of this thesis is health care for the elderly. The social context and background of the elderly person are two contributors to the health-state of the aged person. The positive promotion of health at all stages of life is now recognised as an important factor for the health of the entire community and as the perspective from within which one ought consider the issues of illness and aging. Health and its place in the lives of an aging person and the claims that might be made justly on the Australian public in times of disability, ill-health and dying are central questions in family and political life today. An increasing proportion of the aged in the Australian population, particularly those in the very elderly bracket (the so called *old*-old), appears to be placing great financial and health care burdens on the nation. The increasing costs of caring for the elderly have caused enormous anxiety about the future in many first world nations and will be a recurring theme throughout this thesis. In addition the types of health care Australia should offer its elderly members, whether it be in the home, community based or institutionalised in the hospital, nursing home or hospice, cannot be divorced from the wider issues of population, finance and housing. Development of community care of the aged was driven initially by the need for greater economies in health care delivery. These developments fitted neatly with an ideology that promotes de-institutionalisation of people in care. In this chapter consideration will be given to the relatively recent coordinated use of community care for the aged. The role of families in the care of aging members must be recognised as well since much of the informal care of the elderly in Australia is at present being provided by families. It is against this background that the political dimensions of community care will be assessed. An

account of the national strategy of community care service delivery concludes this chapter's exploration of aged care in Australia.

The five areas described in detail below make clear how complex and inter-related are the issues of aged care in an Australian context. It becomes obvious, too, that both policies and care delivery often evolved in an *ad hoc* fashion, reacting to the pressing needs of the moment. A number of significant values which are sometimes latent in the debate are sketched at the conclusion of this chapter as a bridge to the problematic issues to be raised in chapter 2. This initial and somewhat tentative ethical evaluation of the Australian scene will be taken up in considerably more detail in the concluding analysis of the thesis (chapter 10).

1.1 AGING: SOME INTRODUCTORY COMMENTS

1.1.1 A Question of Definition

It is generally agreed that no one chronological age makes a person old.[1] The difficulty in describing what it means to be *aged* is well put in a recent parliamentary report, *Expectations of Life*:

> The definition (of an aged person) for teenagers is anybody over 30; for the working population, it is retired people; for *healthy* older people it is *unhealthy* older people; for 80 year olds it is those over 100; for Aboriginal people it is anybody over 45; for statisticians it is men over 65 and women over 60; for professional geriatricians it is 75 or when ill-health becomes chronic; for the Department of Social Security it is the same as for statisticians; and in most legislation, it is anyone over 70. The American financier Bernard Baruch (1870-1965) claimed he would never be an old man because 'old age is always 15 years older than I am'.[2]

The Macquarie Dictionary defines the adjective *aged* as "having lived or existed long".[3] What is understood to be a long life depends on life expectancy in a particular

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1 H. L. Kendig and J. McCallum, *Greying Australia. Future Impacts of Population Ageing*, (Canberra: Australian Government Publishing Service, 1988), 1. "The *Aged* cannot be unambiguously defined for policy purposes". Cf. House of Representatives Standing Committee on Expenditure, *In A Home Or At Home: Accommodation and Home Care for the Aged. Report*, (Canberra: Australian Government Publishing Service, 1982), 9 This report is also referred to as the McLeay Report.

2 House of Representatives Standing Committee for Long Term Strategies, *Expectations of Life: Increasing the Options for the 21st. Century*, (Canberra: Australian Government Publishing Service, 1992), 9

3 *The Macquarie Dictionary*, revised edition, (Dee Why, NSW: Macquarie Library, 1985), 76

part of the world in a particular historical period, within a particular group. In addition there are also social understandings of being an aged person. In some societies being an aged person indicates one who has lived long and has much experience. Respect for the elder or wise person is important in such societies. In first world societies of the West, on the other hand, an aged person may be one who has lived long and is no longer a productive member of society or is one who has lived long and whose vital functions are deteriorating.[4] These latter understandings of old age connote notions of senescence, obsolescence and dependency. A working definition of *aged*, therefore, entails two elements: chronology and dependence. At all stages in the human life cycle there is to be found a continuum from independence through to dependence. Persons 65 years or more may be considered to be old in the chronological sense. Their dependency on others may be a separate significant factor in designating them as *aged.* This approach may well provide a useful departure point for what follows. Since aged people are not an homogenous group but portray a range of capacities the criterion of *number of years* is often inadequate. In fact aging is a process with many dimensions including the biological capacity for survival, the psychological capacity for adaptation and the sociological capacity for the fulfilment of social roles. Generally, attempts are made to define the aged as persons in the last third to a quarter of the life span when loss and decline of physiological, psychological and social capabilities are greatest. While there is no universally agreed lower limit to use in the study of aging, 65 years is the most appropriate criterion at this point in time for Australians.[5] Age 65, then, merely defines the lower limit of the relevant age range within which to observe growth of the older population and the changing circumstances of later life. It is not intended as a boundary of old age.

Earlier studies, such as Ford's in 1970, considered 60 years the threshold of old age. More recent authors such as Rowland in 1991 note that the norm of 65 years is almost obsolete in Western first world societies since it is only after 75 years of age that many people begin to decline physically or mentally. In recognition of such variations, the age range of the older population is frequently divided into the *young*, *middle* and *old* old. The *young*-old person maintains a normal active pattern of life. The usual age range is 65-74 years. The *middle*-old applies to those with certain functional impairments who require limited assistance with certain activities but who are still capable of living on their own so long as they get help. This group is usually

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4 Cf. B. Ford, *The Elderly Australian*, (Ringwood, Vic.: Penguin, 1979), 4

5 D.T. Rowland, *Ageing in Australia. Population Trends and Social Issues*, (Melbourne: Longman Cheshire, 1992), 9

in the 75-80 years range. Finally, the *old*-old person is ~~one who is~~ often so frail and ~~generally so disabled~~ as to require constant nursing care and institutional support. People in this category are usually 80 years or more.[6]

1.1.2 The Human Experience of Aging

The experience of the aging individual and the experience of an aging population are two areas requiring closer attention, taken up in more detail in 2.1 below. It will suffice here simply to indicate the broad outlines of the issues. The experience of growing into old age entails physical, psychological, emotional and spiritual dimensions. Two theoretical approaches to this human phenomenon might be noted here. The first, or biological decline model, views aging as the physical deterioration of senescence. The second approach, the social deficit model, focuses on the social roles ascribed to the elderly by society at large.[7]

The aging of entire populations is a new problem for humanity. Almost every time a particular life span has been predicted for a given cohort in this century, the cohort has exceeded the span by the time the predicted age is reached. Regularly enough predictions about health or disease based on the experience of one aging cohort have been inaccurate when the succeeding cohort has aged to the same point. Each cohort of aging people has a particular history. People who were aged 75 in 1947 were born in 1872 and survived their childhood before there was diphtheria anti-toxin. People who were aged 75 in 1966 were born in 1891 and lived through childhood before there was a clean milk supply. They were the survivors of a cohort which lost ten per cent of its infants to acute infectious disease, especially gastro-intestinal disease. People who were 75 in 1981 were born in 1906 and lived through their childhood before there were antibiotics. Persons who are 75 in 1996 were born in 1921 and lived their childhood years without effective screening against tuberculosis or a vaccine against poliomyelitis. Future generations will be the products of particular windows of history which will have a direct effect on their longevity and health and hence the types of needs particular to their old age.[8]

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6 Rowland uses a slightly different categorisation: the *young*-old (65-74 years), the *old*-old (75-84 years) and the *oldest*-old (85 years and over). Rowland, *Ageing…*, 10

7 This delineation of models of aging is to be found in Ford, *The Elderly…*, 9-15. More theories will be developed in chapter 2.1.2.5

8 N. Hicks, A. Braunack-Mayer, and W. Zweck, “Ageing, Well-Being and Research”, *Australian Society*, Supplement (December 1991), 5

As human beings roll back the barriers that block a longer and longer life span the wider demographic implications and their social *sequelae* will require closer attention. It is already obvious that successive cohorts of people will view and experience old age differently. Elderly persons who experienced the Depression and the Second World War have a different set of expectations of old age to those who reared their families in the period after 1950. Children of the baby boom (1950-1970) will approach their senior years (2010-2030) with a quite different set of expectations.[9]

1.1.3 Aging and Measurement

A number of methodological questions must be kept in mind while considering quantitative studies measuring aspects of aging. Examples are to be found in such areas as demography, analysis of needs and risks, assessment for health care etc. The question arises as to what criteria should be used in evaluating the needs of an aging person or a group of elderly people in a community. Anna Howe has proposed a *social indicators* approach for assessing the *aged in need.* Her model measures *social risk* factors. These indicate an elderly person's predisposition to a life of dependence. Such criteria have obvious applicability to the delivery of services and the effectiveness of social policies.[10] Don Rowland adopts a *social integration* model which looks to the extent to which the elderly have opportunities to participate in mainstream society or are separated from it. This is considered to be the central issue in social gerontology because the most significant problems of the elderly are judged to be intrinsically social.[11] These two approaches are a warning that presuppositions implicit in the empirical methods of measurement proposed in the discussion of aged care are of considerable importance for the issues canvassed in this chapter.

1.2 THE DEMOGRAPHY OF AGING IN AUSTRALIA

This brief review of the literature on the demography of aging in Australia considers four areas: past population growth, the present situation, future projections and the implications of this information for an aging society.

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9 House of Representatives, *Expectations of Life*..., 9.

10 "The concept of *being at risk* is often used as a summary indicator of dependency, care need and service response." Commonwealth Department of Health, Housing and Community Services, *Aged Care Reform Strategy. Mid-Term Review. 1990-91*, (Canberra: Australian Government Publishing Service, 1991), 64

11 Rowland, *Ageing*..., 6-8

Australia's aged population (i.e., 65 years and older) experienced its most rapid growth during the last decades of the 19th century when the proportion quadrupled from 1 per cent (1861) to 4 per cent (1901). In 1901 there were 150,387 people aged 65 years or more, thirteen times the 1861 figure. The 75-plus age group grew even more markedly from 2483 to 37,605, a fifteen fold increase.[12] Population growth during the second half of the 19th century was associated with pastoral settlement and the gold rushes. Australia's first experience of an aging population occurred during the 1890s and was one of the factors influencing the introduction of the age pension.

The Australian population has been getting older throughout this century. In 1901 only 4 per cent of the population was 65 or older, and 35.1 per cent was 15 or younger. By 1947, the proportion of the population over 65 had doubled and in 1961 the 0-14 and the 65-plus age groups represented 30.2 per cent and 8.5 per cent respectively of the whole population. By 1989 the 0-14 age group had decreased to 22.1 per cent and the 65-plus age group increased to 11 per cent of the whole population.

1.2.1 The Present Situation

The most recent figures available are to be found in the 1996 census conducted by the Australian Bureau of Statistics:

Age	Males	Females	Total
60-64	340,188	343,578	683,766
65-69	325,810	344,944	670,754
70-74	268,707	318,734	587,441
75-79	175,469	240,246	415,715
80-84	103,256	174,476	277,732
85-89	43,716	94,151	137,867
90-94	12,286	35,617	47,903
95-98	2,331	8,408	10,739
99+	587	2157	2744

Table 1: Australian Bureau of Statistics. *Census of Population and Housing. Selected Social and Housing Characteristics. Australia*, (Canberra: Australian Government Publishing Service, 1997), 36

[12] House of Representatives, *Expectations of Life…*, 11-12

There are 2,150,895 persons 65 years and over in a total population of 17,892,423 constituting 12.02% of the total.[13] The population aged 65 years and over increased by 30 per cent from 1985 to 1994 compared with a general Australian population increase of 13 per cent.[14]

Changes in the age and sex structure of the population 65 and over between 1985 and 1994

Males	%
65-69	31.3
70-79	29.0
80+	58.8
Total aged males	34.1
Females	
65-69	21.9
70-79	23.2
80+	43.5
Total aged females	27.2
Persons	
65-69	26.3
70-79	25.7
80+	48.4
Total aged persons	30.1

Table 2: S. Mathur, *Aged Care Services in Australia's States and Territories,* (Canberra: Australian Institute of Health and Welfare, 1996), 7

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13 The total population consists of 8,849,224 males and 9,043,199 females. Australian Bureau of Statistics, *Census of Population and Housing. Selected Social and Housing Characteristics. Australia*, (Canberra: Australian Government Publishing Service, 1997), 36

14 S. Mathur, *Aged Care Services in Australia's States and Territories*, (Canberra: Australian Institute of Health and Welfare, 1996), 6. In the 1991 census, out of a population of 16,850,540, 1,906,676 persons were 65 years and over making them 11.3% of the total population. Australian Bureau of Statistics, *Census Characteristics of Australia. 1991 Census of Population and Housing*, 11. The Australian Bureau of Statistics data of 30 June 1994 estimated the resident population at 17,838,401; 2,107,673 persons were 65 years and over (912,613 males; 1,195,060 females) and constituted 11.82% of the total population. Australian Bureau of Statistics, *Estimated Resident Population by Sex and Age. States and Territories of Australia June 1994 and Preliminary June 1995*, (Canberra: Australian Government Publishing Service, 1996), 16-17.

It is important to recognise a significant aspect of population aging *within* the aged population itself. During the last two decades the number of people aged 80-plus has increased by more than 100 per cent. It is estimated that this group will double again by the year 2011.[15] These facts and projections have caused Rowland to argue that Australia is approaching its *demographic autumn*, "the end point of a cycle of change where old age structures and zero population growth become characteristic."[16] On the other hand, the dates in Table 3 suggest that there will be at least one more ripple in the process - in the first quarter of the next century.

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15 House of Representatives, *Expectations of Life*..., 15. Changes to the median age of the population indicate the aging of the Australian population: in 1901 the median age was 22.5 years, in 1991 32.5 years, in 1996 34 years; it is projected that the median age in 2011 will be 38.2 years and 41.5 years by 2031

16 Rowland, *Ageing*..., 1

1.2.2 Future Projections

The projected growth of Australia's aged population is as follows:[17]

Increase in population aged 65+, 1981-2031

Year	65+ '000	% inc.	70+ '000	% inc.	80+ '000	% inc.	% total pop.age 65+	% total aged 80+
1981	1455		919		257		9.7	17.6
		16		21		22		
1986	1682		1112		314		10.5	18.7
		17		16		25		
1991	1967		1290		392		11.3	19.9
		13		18		25		
1996	2220		1526		491		12.0	22.1
		8		13		18		
2001	2392		1719		581		12.3	24.3
		9		7		20		
2006	2607		1837		697		12.8	26.7
		13		9		12		
2011	2941		2003		784		14.0	26.6
		18		14		6		
2016	3478		2284		829		16.0	23.8
		15		20		11		
2021	4000		2749		921		17.9	23.0
		14		16		19		
2026	4570		3189		1097		20.0	24.0
		11		15		26		
2031	5064		3655		1386		21.7	27.0

Table 3: Commonwealth Department of Health, Housing and Community Services, *Aged Care Reform Strategy. Mid-Term Review. 1990-91*, (Canberra: Australian Government Publishing Service, 1991), 54

[17] See also House of Representatives, *Expectations of Life...*, 15-16; R. Clare and A. Tulpule, *Australia's Ageing Society*, Vol. 37, EPAC Background Paper, (Canberra: Australian Government Publishing Service, 1994), 18-21

Percentages and sex ratios in the older population predicted for the same period are as follows:[18]

	1961	1986	2001	2011	2021	2031
% in older ages						
65-69	37.3	33.9	28.2	32.0	31.6	28.5
70-74	29.6	28.1	26.3	23.9	27.4	25.3
75-79	18.4	19.3	21.5	17.8	18.6	19.8
80-84	9.6	11.0	13.5	13.9	11.8	14.8
85+	5.0	7.7	10.5	12.3	10.6	11.6
Sex ratios in 65+						
65-69	80.8	87.1	94.2	95.4	91.7	92.6
70-74	79.0	78.8	87.9	88.7	87.3	86.5
75-79	72.3	69.4	75.4	78.5	79.6	76.6
80-84	62.8	56.2	63.1	67.3	67.1	65.3
85+	37.1	36.9	47.6	47.9	46.6	45.8
65+	75.3	72.7	78.0	79.5	79.3	77.0

Table 4: Rowland, *Ageing...*, 29

A few observations are appropriate here. The total population aged 65 years and over increased at a substantial rate from 1981 but the rate of increase abated significantly around 1996 when the smaller birth cohorts of the 1930s reached their 60s. It is not until 2006 that the effects of the post war baby boom flow into the 60-plus group and peak around 2021. Another post-war phenomenon, migration, will also affect the aged population after the turn of the century. The population aged 70 years and over was projected to grow at about 18 per cent during the period 1991-1996. The group 80 years and over is estimated to have increased at the faster rate of 25 per cent during the same five year period and by 1996 will have constituted 22 per cent of the 65-plus population of elderly people.[19]

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18 Sex ratios are the number of males to every 100 females.

19 Commonwealth Department of Health, *Aged Care Reform Strategy...*, 53-55

1.2.3 The Implications of an Aging Population

Two features of the aged population are of importance for what follows. The first is the gender composition and the second is the ethnic composition of Australia's aging population. Elderly women far outnumber elderly men. In 1989 the sex ratio was 99.7 males per 100 females overall, but 73.8 males per 100 females among those aged 65 and over. At ages above 85 years women outnumber men two to one. Women outnumber men at later age groups because women have lower death rates at all ages and thus greater life expectancy. The implication of this situation is that issues affecting the elderly, especially after the age 75, are issues that principally affect elderly women.[20]

Australia's aged population is rapidly becoming more ethnically diverse and the overseas born are expected to be the source of the greatest increase in the size of the 65-plus age group during the coming decades. Ageing of the large migrant intake over the early post war years is now beginning and by 2001 it is expected that the ethnic aged will account for around 25 per cent of those aged 60 years and over.[21]

Most demographic authorities in Australia agree that the age structure of a society is shaped by three factors: fertility, mortality and immigration. While recognising the highly technical nature of the data on each of these factors and, at the risk of over-simplification, a few comments seem appropriate.[22]

First, *mortality*: life expectancy has increased throughout this century as the following table indicates.

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20 House of Representatives, *Expectations of Life…*, 18

21 Commonwealth Department of Health, *Aged Care Reform Strategy*, 76; see also House of Representatives, *Expectations of Life…*, 18

22 This section is dependent on: House of Representatives, *Expectations of Life...*, 18-24; See also A.H. Pollard and G. N. Pollard, "The Demography of Ageing in Australia" in *Towards an Older Australia. Readings in Social Gerontology*, edited by A. L. Howe, (St. Lucia, Qld.: University of Queensland Press, 1981), 13-34; C. Young, *Australia's Ageing Population - Policy Options* (Canberra: Australian Government Publishing Service, 1990)

Expectations of life at birth

Year	Males	Females
1881	46.5	49.6
1891	47.2	50.8
1901	51.1	54.8
1911	55.2	58.8
1921	59.2	63.3
1933	63.5	67.1
1947	66.1	70.6
1954	67.1	72.8
1961	67.9	74.2
1966	67.6	74.2
1971	68.1	74.8
1976	69.6	76.6
1981	71.2	78.3
1986	72.6	79.8
1996	73.5	80.2
2021	75.4	84.5

Table 5: House of Representatives, *Expectations of Life...*, 19, Table 2.5

Until the late 1970s, it was widely thought that by the post-transition stage of the demographic transition, age-specific mortality rates at older ages had stabilised. Supporting this were: (1) the normal life span of 70 had not been extended, (2) improvements in life expectancy at birth had been due predominantly to the reduction in mortality at younger ages, (3) there had been a shift from controllable infectious and parasitic diseases to chronic and degenerative diseases that are difficult to treat.[23] By the 1980s, however, declining mortality was a major cause of population growth. The 80-plus group increased by 40 per cent between 1981 and 1989 while the increase in the 65-plus population was 28 per cent. These increases were much greater than the 13 per cent increase in the population as a whole. The 1980s brought a realisation that the demographic tranquillity envisaged in transition theories had not eventuated. Australia is now in the middle of a new and previously

[23] Rowland, *Ageing...*, 42-43. The *epidemiologic transition* referred to here identified three stages differentiated mainly according to rates and causes of death: (1) the age of pestilence and famine, (2) the age of receding pandemics and (3) the age of degenerative and man-made diseases.

unexpected period of changes in death rates, as well as birth rates, which will have far reaching effects on the numbers and proportions surviving to advanced ages.

> When mortality decline is added to the effects of cohort flow and demographic ageing, the older ages emerge as the most changeable segment of society, one in which rapid turnover is characteristic and the past experience of survival and longevity is an unreliable guide to the future.[24]

The second main influence on a population's age composition when mortality is low is the level of *fertility*. Continued low fertility will produce a relative decline in the proportion of young people and a rise in the proportion of the elderly. Low and declining fertility has been Australia's experience since the early 1960s. The total fertility rate rose steadily each year from 1948 until its peak of 3.5 in 1961. This was followed by a sharp decline to 2.88 in 1966, it stabilised until the early 1970s and then followed another sharp fall. The total fertility rate first fell below replacement level in 1976 (to 2.06) and has not risen above this number since. While there was a modest recovery in fertility rates in the early 1980s, this was followed by the return of the downward trend in the latter half of the decade.[25]

As has been mentioned above, *immigration* has had a significant impact on Australia's age profile. Initially migration tended to keep down the proportion of aged people in the community. However, as the young migrants of the post-war period reach retirement they contribute to the growth of the 65-plus age group. It is interesting to note in this context that during the 1980s Australia had the highest rate of population growth of any Western country largely due to its high level of immigration. "Australia's total net migration during 1988 was also about twice as high as its average net intake over the previous 44 years."[26] This will have long term consequences for the profile of aging in the next century.

Reference should be made here to the relative importance of the three factors. Contrary to popular belief, "it is not falling mortality that is the major factor producing changes in the proportion of aged persons in the community, but rather the effect of changing fertility."[27] Immigration has relatively little effect on the age structure of the population in both the short and long term. Population aging is largely a consequence of events affecting the base, rather than the apex of the

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24 Rowland, *Ageing…*, 56

25 House of Representatives, *Expectations of…*, 21

26 Young, *Australia's Ageing Population…*, xi

27 Pollard and Pollard, "The Demography..." in *Towards an Older Australia…*, 18

population pyramid.[28] Population aging, measured in percentage terms, occurs principally when there is a decrease in the representation of the young, a change brought about through lower fertility. If fertility is high, the largest age groups in the population will always be at the base of the population structure because children outnumber their parents. Population aging entails an evolution from a *young* triangular age structure to an *old* rectangular one, a process requiring fertility around replacement level. As Young observes:

> [m]aintaining near-replacement fertility is a more efficient way of retarding the ageing of the population than maintaining a high level of immigration, because the same effect on the proportion of the elderly is achieved through a smaller increase in the total population. In addition, a small change in the level of fertility has a greater effect in retarding the ageing of the population than does a large change in the level of net migration.[29]

The growing awareness of aging in the Australian community and the higher level of concern as to its consequences comes less from the growth of the aged population than from the possible economic consequences for workers and tax payers. The dependency ratio which expresses the relative sizes of the *productive* and *non-productive* sectors of the population is of central concern. Considerable discrimination is required regarding this so called *dependency ratio*. It may be constructed on age alone, or more finely on the basis of those of working age (viz. 15-64 years) or perhaps more accurately on the basis of labour force figures. The numbers offered and projections made indicate that the concern in the wider community does not stand up.[30] It has been suggested that "the more rational fear with respect to demographic change (if there has to be fear at all) would seem to pertain more to the consequences of increases in *size* than to a decline in the *rate* of population growth or a shift toward an older age distribution."[31]

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[28] Rowland, *Ageing...*, 18. Three aspects of demographic analysis are relevant here: demographic *transition*, demographic *momentum* and *dependency*. In regard to the first of these the initial maintenance of high fertility joined with falling death rates creates rapid growth and a more youthful age structure with an exceptionally high proportion of children. Later as birth rates decline the process of demographic aging commences so that by the end of the transition the representation of children reaches the lowest level so far, while the percentage of aged 65 and over grows to about four times that seen in the transitional stage. This results in the *rectangularisation* of the age profile. The growth resulting from this rectangularisation is known as *population momentum*. Potential for growth at this stage is due to the differences in size of the generations. (*ibid.*, 18-22)

[29] Young, *Australia's Ageing Population...*, xii

[30] House of Representatives, *Expectations of ...*, 22-24; cf. Clare and Tulpule. *Australia's Ageing Society*, 14-18

[31] L.H. Day, "Social and Economic Implications" in *Towards an Older Australia. Readings in Social Gerontology*, edited by A. L. Howe, (St. Lucia, Qld.: University of Queensland Press, 1981), 49

It is important to note that total dependency is greatest in transitional populations. Here it is children who constitute the largest dependent groups. By the end of the demographic transition, however, the higher dependency burden of an aging population is more than offset in terms of numbers, but not financial costs, by reduced child dependency. As the momentum of growth works through the modern stationary or post-transitional population child and aged dependency ratios converge to similar levels of about thirty per 100 persons of working age people. It is important to note here that private expenditure on dependent age groups is much higher for children than for the aged since the greater part of support for children is provided by parents. The majority of the elderly, however, rely on government income support from pensions or tax subsidised superannuation benefits. This shows up as greater governmental expenditure. It is Rowland's opinion that the overall level of dependency in the population, demographically speaking, will increase only slowly in the future.[32] The *modern* population emerging at the end of the demographic transition has a much younger age structure than that of the later *modern stationary* population. The former represented Australia's situation in the 1980s. The ratios projected for 2021 in Australia are similar to those for the *modern stationary* population as indicated in the table following:

Age structures and dependency ratios for model populations

	Primitive stationary	**Pre-modern**	**Transitional**	**Modern**	**Modern stationary**
Ages (%)					
0-14	36.2	37.8	45.4	27.2	19.2
15-64	60.9	58.8	52.0	62.4	62.3
65+	2.9	3.4	2.6	10.3	18.5
Dependency ratios					
Child	59	64	87	44	31
Aged	5	6	5	16	30
Total	64	70	92	60	61

Table 6: Rowland, *Ageing…*, 21

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32 Rowland, *Ageing…*, 25

The movement of large cohorts into the later working ages will gradually raise the representations of ages 15-64 in the total population to a record of 67 per cent in 2011, after which the figure will fall as the baby boom cohorts retire. The rise in the percentage in the working ages will entail an aging of the labour force which is an inevitable forerunner for the attainment of a *modern stationary* age profile; the proportion of the population aged 45-64 could rise to 28 per cent by 2021, compared with 20 per cent in 1981.

While concepts of dependency are useful, study of the aged requires recognition that a majority of the elderly are not dependent, except as recipients of a pension. In fact dependency is multidimensional.[33] For this reason policies regarding the aging of the population cannot be considered in isolation but must be part of a total population policy. Australians must ask what sort of society they wish to be. In the context of answering this question it will be necessary to consider issues such as the well-being of the population, environmental and resource limits to further population growth, the ability of the capital city infrastructures to cope with continued population growth, immigration, youth unemployment, the housing crisis, the integration of occupational superannuation and pension schemes, the female labour force, child care and education funding.[34]

1.3 THE ECONOMICS OF AGING

1.3.1 Aging People, Work and Employment

Australians are living longer and retiring earlier. In 1911, 72 per cent of men in the 65 to 70 year old age bracket were still in the work force at a time when the average life expectancy was 55 years. By 1961 the percentage had fallen to 40.1 per cent. In 1984 only 10 per cent of this cohort were employed at a time when life expectancy had extended to 72 years.[35]

The decision to retire hinges on three factors - state of health, the level of retirement income envisaged by the retiree and the present level of work satisfaction. A number of voluntary and involuntary factors have been proposed as causing a fall in the number of older workers in the labour force. These are significant. Voluntary factors

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33 Rowland, *Ageing...*, 27

34 Cf. Young, *Australia's Ageing Population...*, xiv

35 House of Representatives, *Expectations of Life...*, 25; see also Rowland, *Ageing...*, 130-134

include increased superannuation coverage, higher income from rent, dividends and interest, home ownership at an earlier age, the availability of pensions to veterans at 60 years of age and a possible increased preference for leisure time. Among the involuntary factors is the discouraged worker effect of recessions since 1974. Unable to find work the discouraged worker drops out of the workforce. Older workers have been disproportionately affected by unemployment mainly because they are concentrated in declining industries. Retrenchment policies have also discriminated against older workers as have employment policies which pit older workers against younger people in a tight employment market.[36]

Attitudes present in the community should not be underestimated. Older people see themselves as too old for re-employment. This links with an aversion among employers against recruiting older workers. There is a wide-spread perception that older workers are not open to or easily able to be retrained. Less emphasis has been given to subsidies for re-employing older unemployed people, particularly blue collar workers, in comparison to the expenditure given to the younger long-term unemployed.

A number of issues must be recognised as relevant for the continued employment of older people. First, the question of compulsory retirement. "Retirement at age 60 or 65 is largely a matter of employer policy, a convention reinforced by a number of social security, tax, superannuation and attitudinal factors."[37] In addition attention must be given to flexible working arrangements, training and retraining in the workforce and the place of volunteer activity in the community.

Central to any discussion of retirement is an understanding of work, or more accurately paid employment. *Expectations of Life* aptly portrays the place of each in human existence today:

> Work is central to all economic and social life and probably to the human condition itself . . . Paid employment provides the income which is so important for quality of life, the identity which is so important for self-esteem and social confidence, and the meaningful activity which is so important for feeling useful and avoiding boredom. Work is critical to self-recognition or definition ("I'm a plumber") and community recognition ("he/she's still working"), with its coded implication, "He/she is still useful".[38]

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36 House of Representatives, *Expectations of Life*..., 29

37 House of Representatives, *Expectations of Life*..., 39. The issue of discrimination on the grounds of age requires legislative expression. South Australia has already introduced legislation outlawing discrimination on the basis of age.

38 House of Representatives, *Expectations of Life*..., 25

Paid employment, together with the capacity it gives for acquiring material possessions, has contributed greatly to the *extrinsic* valuation of individuals in our society. Aging and retirement are viewed as removing the individual from the mainstream of life. It implies their entry into a group of the *useless*, on a par with children, the unemployed and dole bludgers! It has been suggested by one author that the great emphasis given to employment camouflages two tensions in the contemporary Australian psyche. Paid employment and all that it brings is an escape from boredom. It also means that "we live by timetables: the whole social framework of order, discipline and authority depends on the 'external' organisation of time, not on self-management."[39] Inability to value time and the self as of *intrinsic worth* diminishes the capacity to respond to the place of work, employment and leisure in an evolving post-industrial society.[40] Therefore any consideration of aging must be accompanied by analysis of the place of work in human living, the changing role of employment and its patterns of expression, notions of being useful or useless, perceptions of time in contemporary living and attitudes to leisure both before and after retirement.

In an era when economic rationalism is rampant "[t]he belief that the elderly are not important consumers affects their lifestyle options and is a considerable misunderstanding of the nature of older people's purchasing power."[41] Expenditure on such things as food, leisure and other necessities is a barometer of the specific needs of this particular group.

1.3.2 Retirement Income

The capacity to live a relatively good quality of life after retirement from the work force hinges, to a considerable degree, on having a secure financial base for the years remaining until death. Post-retirement income is, therefore, of considerable significance for the issues to be analysed in this thesis. It is indicative of Australian society's concern for the elderly and concretely illustrates the ways technical solutions are sought by government to problems of aging through specific economic

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[39] House of Representatives, *Expectations of Life...*, 85. Chapter 5 of the Report was influenced by the work of Barry Jones MHR., especially his *Technology and the Future of Work. Sleepers Wake!* (Melbourne: Oxford University Press, 1990), 80-121, 190-209

[40] In addition to the psychological and philosophical aspects of life in contemporary Australia attention must also be given to the role of technology in the future and the changes of employment it will cause. Cf. H. Mackay, *Reinventing Australia. The mind and mood of Australia in the 90s*, (Sydney: Angus & Robertson, 1994), 85-110

[41] H.L. Kendig and J. McCallum, *Greying Australia. Future Impacts of Population Ageing*, (Canberra: Australian Government Publishing Service, 1988), 36

policies. The great variety of changes to the pension scheme that will be briefly outlined show a preference in Australian old age policies for re-active, economically driven solutions to perceived problems. The variability of pension schemes since the Second World War suggests that the wider issues of an aging population which will be considered in the following chapter are subservient to the imperative of the *quick fix* at the level of economic expenditure. Ian Manning observes that the public pension was the main source of income for people aged 65 years and over in Australia by the beginning of the 1990s.

> This supplies over 50 per cent of all cash income received by Australians in this age group, and forms the principal source of income for 75 per cent of older people . . . The main questions which arise concern its adequacy, both now and prospectively, and its relationship with the other main sources of income for people aged 65 and over - asset incomes (28 per cent of total income) and earned incomes (14 per cent of total income).[42]

Manning further asserts that post-retirement finance is frequently discussed in terms of an economic theory in which people are assumed to have saved during their working lives and will deplete their savings to finance their retirement. In this theory the public pension is a substitute for private savings. The pension is funded from general revenue at a flat-rate and is means-tested. It is the main equalising structure in the retirement income system.[43] At this point it is relevant to advert to the occupational superannuation component of retirement income. This, it has been argued, is *the* factor that makes for inequality in post-retirement income for aging people. McCallum proposes that "along with poverty alleviation and income replacement . . . equal access to means of saving for retirement should be a third national goal . . ."[44]

Financing the pension has received increasing consideration during recent years. Two views on the impact of population aging on government expenditure have dominated analyses. The first view sees a major funding crisis developing that will necessitate either large increases in taxes or cuts in government benefits and services. The second approach is less pessimistic. Economic growth and policy adjustments will be

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[42] I. Manning, "Savings or the Pension: The Consequences of a New Life Cycle" in *Grey Policy. Australian Policies for an Ageing Society*, edited by H. L. Kendig and J. McCallum, (Sydney: Allen & Unwin, 1991), 74

[43] J. McCallum, "Winners and Losers in Retirement Income" in *Grey Policy. Australian Policies for an Ageing Society*, edited by H. L. Kendig and J. McCallum, (Sydney: Allen & Unwin, 1991), 56

[44] McCallum, "Winners and Losers...," in *Grey Policy...*, 57. This argument might have been altered by the legislation of a superannuation guarantee scheme in the early 1990s, but for a rapid growth in the proportion of part-time employment.

sufficient to deal with a progressively aging population.[45] Both approaches must be viewed in the context of the historical evolution of the aged pension in Australia. [46] The depression of the 1890s and the aging of the immigrant population that arrived as part of the gold rush placed considerable pressure on the charitable organisations of the day. During the period 1895 to 1908 Victoria and N.S.W. attempted to develop a welfare policy for the aged that would (1) supplement the relief provided to the deserving aged poor by relatives and charitable agencies, (2) provide this assistance in a way that would not discourage thrift and self-reliance, and (3) be a fair and reasonable amount for the community to provide. It would seem in retrospect that these three objectives have continued to the present day. The Commonwealth funded pension was not introduced until 1908. It evolved over the next half century so that by the late 1960s the aged pension was widely regarded

> simply as a measure of assistance for the elderly - as a means of supplementing the pensioner's own resources or, if he had none, of making it possible for him to be supported by his family in their home . . . [It] has never been regarded by any government as a sum designed to maintain a person completely, but something which is supplementary to their own savings.[47]

The Henderson Report on Poverty in Australia in 1966, it has been argued, contributed to a decisive shift in political and public opinion regarding the aged pension. From this time it was seen as a safety net providing the individual aged person with enough to live on in a modest way without any other forms of assistance.

> Our present age pension system seeks to ensure that no one falls into destitution. Wage-related pensions still retain that aim but also aim to provide a safeguard against the loss of an acquired standard of living.[48]

Six variables in the delivery of the pension throughout this century highlight the priority given to technical economic responses to the demands of an aging community. First is the basic pension rate. During the 1970-1990 period the pension rate increased as a percentage of average weekly earnings. However, prior to that it fell from 27 per cent after World War II to 21.2 per cent by 1967-68 to 19 per cent in the early 1970s reaching 24 per cent by 1986.[49] From its inception the age pension

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[45] Kendig and McCallum, *Greying Australia...*, 54

[46] Cf. J. Dixon, *Australia's Policy Towards the Aged: 1890-1972*, (Canberra: Canberra College of Advanced Education, 1977), 1-7; see also J. Dixon, "The Age Pension: Developments from 1890 to 1978" in *Towards an Older Australia. Readings in Social Gerontology*, edited by A. L. Howe, (St. Lucia, Qld.: University of Queensland Press, 1981), 65-81.

[47] H.M. Pritchard, "Income Requirements of the Aged" in *The Aged in Australian Society*, edited by S. Sax, (Sydney: Angus and Robertson, 1970), 75

[48] Pritchard, "Income...," in *The Aged...*, 80

[49] Pritchard, "Income...," in *The Aged...*, 77; cf. Rowland, *Ageing...*, 135

has operated with a maximum amount as its ceiling. Changes in this amount and the abandoning of the uniform pension principle after 1963 meant that unmarried age pensioners obtained a greater return than that offered to married pensioners. In 1969 the *tapered means test* was introduced and this was followed by the introduction of automatic cost of living adjustments.

Eligibility for the pension constitutes the second set of variables. The *exclusion means test* applied to the pension after 1908 was initially extremely restrictive. Over the years it has undergone substantial modifications. The complex nature of this test focused on the value of property owned by the applicant and the income received during a designated period. Among the other eligibility tests applied during the course of this century have been age, race or nationality, residency, morality and domicile.[50]

The third set of variables in pension delivery is to be found in the range of benefits included in the pension, e.g. medical expenses, pharmaceuticals, telephone costs, rate allowances. Tax concessions on income have also played varying roles in the economics of pension delivery. In addition, supplementary assistance for persons who are solely dependent on their pension has enabled the state to support pensioners in a selective fashion. Despite these extra benefits the Australian pension is not as generous, in relative terms, as that provided in other countries especially in Europe.[51]

The economic cost of providing pensions to the aged is the fourth variable in the economics of the pension. Commonwealth expenditure on the aged increased from 2.7 per cent of the total economy in 1965-66 to 5.7 per cent in the year 1982-83. The increase during this period was due more to policy changes than to a significant growth in our aged population. Comparisons between age groups indicate the size of expenditure outlays. In the year 1980-81 persons in the 60-64 years age group received $2346 per person in benefits. Persons aged 75 years and over received $5609. In the same period elderly people in Australia received $7600 million or $3781 per person. Older people thus "received nearly one-third of government expenditure on health, welfare and related areas, although they made up only 13 per cent of the population."[52] Expenditure on the elderly is likely to increase somewhat faster than expenditure on the working age population until 2000. Projected

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50 Dixon, "The Age Pension...," in *Towards an Older Australia...*, 71-72

51 John Myles in *Old Age in the Welfare State: The Political Economy of Pensions*, (Boston: Little, Brown and Co., 1984) argues that all national pension systems entail a compromise between citizenship and class. In chapter 3 he compares fifteen capitalist democracies and ranks Australia last among them.

52 Kendig and McCallum, *Greying Australia*, 56

expenditure on the aged is estimated to rise by more than 50% in real terms in the period 2000-2021.

The fifth variable that must be considered is the sex distribution of recipients of the aged pension. As early as 1969 Wryell observed that in that year there were 705,000 aged pensioners, 70 per cent of whom were women. At that time also half of all aged pensioners were single women. As noted earlier, the sex ratios in the elderly population continue this phenomenon. Its implications for support of elderly single women whether at home or in an institutional environment will be explored in the next chapter in greater detail.

The final variable in assessing the impact of pensions in the elderly community and for the Australian population as a whole is the proportion of the aged who are not receiving a pension. In 1969 about 45 per cent of people of pensionable age were not receiving the age pension. This fell to 22.6 per cent in 1981. By 1986, however, the proportion had increased to 33.9 per cent and has remained relatively constant since then.[53]

Retirement income policies in Australia have been undergoing considerable change and uncertainty in recent times. The 1970s were characterised by implicit, bipartisan political party support for universalist public schemes, including national superannuation and guaranteed minimum income. That stability began to collapse in the 1980s, with

> ever-tighter means tests and more incentives for private provision of retirement income . . . Retirement income policy is now in ferment. Between mid-1987 and the end of 1988 there were seven amending Acts to the *Social Security Act*, most of which were substantial.[54]

In general, recent developments on both the revenue and benfit side of retirement incomes indicate the government's increasing concern that Australia will be unable to support the financial needs of an aging population.

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[53] 39.3 per cent of persons of pensionable age were not receiving the age pension in 1991. In the 1996 census year the proportion was 35.7 per cent. The Department of Social Security provided data regarding the number of recipients of the age pension. Cf. Australian Bureau of Statistics, *Census 86 - Summary Characteristics of Persons and Dwellings. Australia*, (Canberra: Australian Government Printer, 1989), 8, and *Census Characteristics of Australia. 1991 Census of Population and Housing*, (Canberra, Australian Government Printer, 1993), 13

[54] McCallum, "Winners and Losers...," in *Grey Policy...*, 55; Clare and Tulpule, *Australia's Ageing Society*, 45-68

1.4 HOUSING ELDERLY AUSTRALIANS

1.4.1 The Domestic Needs of the Elderly

The physical dwelling and the meaning this has for the individual increases in importance as a person ages. For the aged, without regular employment responsibilities and with reduced personal mobility, more time is spent in and around the home. The comfort and conveniences of the dwelling itself and the close accessibility to shops, public transport and other services becomes more important and is often critical for the welfare of the frail aged. For those in their own homes, the house is often a reminder of the past and a help in maintaining a sense of identity and purpose as adjustments have to be made in their later years. Home ownership is often the only form of wealth and evidence of status for the aged. For those renting their dwelling, the cost often takes a large share of their reduced incomes.[55]

A user-friendly environment is even more important for elderly people as they begin to lose the mobility of earlier years. While they, as a group, have social needs no different from others in the community some elements of social and community living are significant. Identification with society, the retention of a sense of usefulness and a desire to feel secure against many of the multiple stresses to which they are subjected, are basic social requirements of the elderly.[56]

1.4.2 Types of Accommodation Used by Aging People

There may well be a temptation, in considering care for the aged, to limit one's consideration to institutional care environments, such as the nursing home. Howe correctly points out that

> nursing home care is directly concerned with only a minority of the aged population, and usually for only a short period of their lives. Only about five per cent of the aged reside in nursing homes at any one time.[57]

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[55] Cf. H. Kendig, "Housing and Living Arrangements of the Aged" in *Towards an Older Australia. Readings in Social Gerontology*, edited by A.L. Howe, (St.Lucia, Qld.: University of Queensland Press, 1981), 85

[56] Cf. A. Foster, "Housing and Welfare of the Aged" in *The Aged in Australian Society*, edited by S. Sax, (Sydney: Angus and Robertson, 1970), 94

[57] A.L. Howe, "Nursing Home Care Policy: From Laissez-Faire to Restructuring" in *Grey Policy. Australian Policies for an Ageing Society*, edited by H. L. Kendig and J. McCallum, (Sydney: Allen & Unwin, 1991), 151

The aging person may be found in any of five categories of accommodation: (1) owning his or her own home, (2) renting, (3) boarding, (4) living with family members, or (5) residing in a retirement village.

First, home ownership provides low housing costs, security of tenure and a sense of pride and accomplishment in the context of the elderly person's life story. The home is also a substantial asset that offers the aging person both a spring-board to financing more suitable accommodation as the years go on and the possibility of leaving a considerable estate to heirs. The advantages of home ownership are both profound and practical. In addition to the sense of belonging there are the advantages of familiarity with the area and proximity to friends and neighbours. When the elderly person resides in an established suburb, there is usually a good network of transport and services. Home owners are relatively rich in assets but poor in income. Maintenance of property becomes an increasing burden and a greater cost because of dependence on others. Married couples who move on retirement to a warmer climate or along the coast, at times far from their family, often experience difficulties when one spouse dies or when either becomes frail. At this time they do not have the financial resources to move nearer to their family and friends. As a result pockets of elderly and isolated individuals with their own homes become an increasing human and social problem in the favoured retirement centres along our coasts.

Second, elderly persons renting accommodation are less well off than those owning their own home. Their average incomes are less than those of home owners yet their average housing costs are much higher.[58] Private renters are, according to Kendig, in a state of double jeopardy

> for their old age frequently culminates a life-time of economic hardship and a lack of strong family relationships. Private tenants make up a large share of the renters who reside in unsatisfactory housing . . . or who are dissatisfied with the quality of their housing.[59]

Increasing rentals mean that a disproportionate amount of the renter's income goes to accommodation. While this is frequently offset by living in inner city areas with a wide choice of dwellings, good transport and nearby shops, all who rent lack security. This becomes an increasing problem for aged persons who are frequently single and female.

The third group consists of boarders (sleeping quarters and meals) and lodgers (sleeping quarters only). These persons are an even more deprived group among the

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58 Kendig, "Housing...," in *Towards an Older Australia...*, 91

59 Kendig, "Housing...," in *Towards an Older Australia...*, 90-91

elderly. This type of accommodation is becoming less common due, in large part, to the application of health and safety regulations to boarding houses. A particular sub-group among those who board or lodge are people who have been for some time resident in psychiatric institutions or special institutional care. Increasingly these people are lodged in unsatisfactory accommodation without any personal support networks.

Elderly people living with their family compose the fourth group. The proportion living this way has fallen in recent years. A number of factors have caused this trend. Availability of the phone and car have reduced the necessity of co-residence. Working mothers, smaller family size and limited dwelling space have been factors in the change. For those living with families access to and availability of domiciliary care or respite care is of critical concern. At the policy level tax concessions are unfavourable to co-residency arrangements as is local government resistance to the construction of granny flats. Recent changes in policies governing cities now favours denser living levels in both city centres and the suburbs.

The fifth form of accommodation for the elderly to be considered is the retirement village. These proliferated with funding support under the *Aged Persons' Homes Act* (1954). The Act was a major turning point in Commonwealth involvement in providing special accommodation for aged people. For twenty years it gave priority to institutional over community care of the aged by providing extensive funds that favoured hostels and nursing homes.[60]

Two issues ought be mentioned here in reference to the existence of retirement villages. First, whereas villages and their financial arrangements vary greatly, all have two key features: (1) leasing or loan arrangements enable older owners to make direct use of the capital from their former homes, and (2) villages provide opportunities to move to dwellings less difficult to maintain, provide the company of older people and deliver some supportive services. Taken together, these features provide a privatised and potentially comprehensive option for securing supportive accommodation. In the early phase of the growth of retirement villages access to them was limited to persons with sufficient financial resources, except for a minority of places supported by churches and charitable organisations. More recently State and Commonwealth parliaments have sought to protect the consumer through the introduction of legislation and codes of practice governing the retirement home industry.

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[60] Kendig, "Housing...," in *Towards an Older Australia*...,102-103

Second, the question must be asked as to the rationale of the retirement village. The prevailing *disengagement theory* of aging in the 1960s justified the development of large institutions for the elderly, segregating them from the wider population. This approach considered that in the normal run of things an elderly person's range of interests contracted. Sociologists from a more critical school of thought rejected this approach. They argue that it is just as likely, or even more likely, that aging people are distanced from social structures by the very nature of those structures as that they choose to distance themselves as they age.[61] Undue emphasis on the psychology of withdrawal in the aging process ignores the sociological fact that an onging exchange between the elderly, their family and their peers is vital for the personal well-being and lives of the elderly. The strengths and weaknesses of secluding the elderly in retirement villages has important implications for later consideration of health care of the aged, especially the types of care that they require.

1.4.3 Issues Related to the Housing of the Aged Population

It has been argued that a coherent housing policy for older people does not exist in Australia.[62] Yet the housing of elderly persons is being directly and indirectly affected by decisions made at all levels of government. The high level of home ownership among older people today reflects the favourable housing markets of the 1950s and 1960s and the numerous government policies subsidising home ownership. In 1986, 72.4 per cent of the elderly were in dwellings owned outright, 9.1 per cent were in mortgaged dwellings and 18.5 per cent were renting.[63]

Reference has already been made to the impact of housing costs on the standard of living of elderly people. In terms of weekly costs elderly persons renting on the private market have the greatest outlay on accommodation. The provision of public housing and rent assistance has greatly helped poor tenants among whom are numbered the very old, the working class poor and women who have never married.[64]

State and local governments have a great impact on the neighbourhood in which elderly people live. Land use policies and building regulations influence the availability of boarding houses and the provision of newer higher density housing in established suburbs. Conflicting agendas create difficulties. State governments, in

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[61] Hicks et al., "Ageing…," *Australian Society*, 11

[62] Kendig, "Housing...," in *Towards an Older Australia…*, 92

[63] These figures exclude the elderly already dwelling in institutional settings. Rowland, *Ageing…*, 64

[64] Kendig, "Housing...," in *Towards an Older Australia…*, 95-98

seeking to limit city sprawl, favour new higher density residential areas in established suburbs. Local governments, on the other hand, oppose any developments that degrade their area and its amenities.

The particular shape of community services for the elderly will be considered in more detail below. Of particular importance for elderly home owners is the need for assistance in maintenance of buildings and grounds. Mention has already been made of the need for transport to shops and other services. Community services, their availability and priorities, must promote the independence of aged people and their personal care.[65]

Commonwealth-State Housing Agreements have been a significant instrument in the provision of public funds for housing. Older people were not high on the priority list of the first agreement in 1945. It was not until the *States Grants (Dwelling for Pensioners) Act* of 1969 that a major re-direction of funds to the elderly took place. Subsequent Acts in 1974 and 1984 widened the criteria of eligibility for the funds provided. By 1986 persons aged 60 years and over accounted for nearly a quarter of all households in government housing.[66]

1.5 HEALTH, HEALTH CARE AND THE AGED

1.5.1 Health and the Elderly

1.5.1.1 The Social Dimension of Health

There is a real danger in viewing the aged as an homogeneous group. This may occur by using chronological age, disability or ill health as a criterion. It may also occur by designating this group simply as retirees and, by implication, non-productive dependent members of the community. Such assumptions are false and deceptive.[67] Later in this thesis it will be necessary to develop the tension between (1) stereotyping the elderly as an homogeneous group and (2) an anti-ageist ideology emphasising liberal individualism which focuses on the differences between elderly persons often portraying them in terms of a healthy, active middle age. It is sufficient

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65 Kendig, "Housing...," in *Towards an Older Australia...*, 101

66 The McLeay Report gives a survey of federal government initiatives up until 1982. Cf. House of Representatives, *In A Home Or At Home...*, 31-49

67 G. Andrews and S. Carr, "Health Care for the Aged" in *Grey Policy. Australian Policies for an Ageing Society*, edited by H. L. Kendig and J. McCallum, (Sydney: Allen & Unwin, 1991), 111

here simply to recognise the great diversity of elderly persons in Australia on a number of grounds: be they *young-*, *middle-* or *old*-old, be they vigorous or frail, healthy or ill, acutely or chronically sick, active, impaired or disabled.

A number of implications for an aging Australia need to be borne in mind. First, health services will have to direct their attention increasingly from the acute illnesses of the young to the chronic sickness of old age. Because of the greater life expectancy of women (stabilising at 6.5 to 7 years more than that of men), 60 per cent of Australians over 65 and 75 per cent of those over 85 years will be women. This means that care of the very old is principally the care of elderly women who are increasingly burdened as they themselves age.

The health of Australians, and the significant differences in levels of health, are considered by the public health community to be expressions of socio-economic differences in the community. Three areas of differences in the health of the Australian community are significant: aboriginality, gender and age. Life expectancy in the aboriginal community, for those who survive past age 2, is 25-30 years and is radically influenced by the complex set of disadvantages suffered by the members of this community. Caring for an increasing elderly population is, therefore, a relatively insignificant issue for the aboriginal population as a whole. Gender is the second important factor. Women not only live longer but experience more disability and handicap than men. Some authors suggest that a poor understanding of reproductive health and the feminisation of poverty are significant factors in any analysis of women's health. On the issue of age, when use of public hospital beds is used as a criterion, it is clear that the elderly are four times more likely than the general population to use such facilities. Thus the health and ill-health of the older members of our community is an important concern, even if this is viewed solely in terms of the burden they place on the wider community.

The health or ill-health of the aged is determined by life-time patterns. Preventive measures and education of the young will be significant influences for change in the future. Past experience suggests that improvements in the health services alone will not radically alter the standard of health of the aged population. Social and educational changes may well be more important. This was the case where changes in sanitation and education contributed to a decrease in infant mortality and an increased life expectancy during the period 1900 to 1950.

The relationship between poverty and health has been well established. While the mechanism by which poverty influences the health of people is not clear two explanations are offered. The first emphasises the structural factors in modern life.

Poorer people work in more hazardous jobs, live in more polluted and dangerous environments, live in less adequate housing and eat less healthy food. The second explanation points to the alienation of poorer persons. If the poor have any work at all it is often stressful and unfulfilling. They are often isolated from support and information. These conditions could lead to poor health through high risk behaviour such as smoking and drinking. Indirect factors, much less well understood, suggest that people with poorly developed social networks get sick more often and take longer to recover from illness.[68]

This sketch of some social constituents of health and ill-health is extremely important for any study of the health of aged people and the nature and quality of health care offered to the elderly. The aged are now frequently among the poor and their number and proportion will, in all likelihood, increase. Women, particularly in the old-old group, will be disproportionately represented among the poor.

1.5.1.2 Health, Illness and Aging

The stereotypical view of aging in Australia is that old people are a problem absorbing ever greater time, attention and resources, that aging is an illness and disabling illness is inevitable in old age.[69] None of these views is necessary: health at any stage of life can be considered from a wider viewpoint than the merely physiological. Health is recognised by many in the lay community and by a significant fraction of health professionals as being a matter of well-being, a *synergism* of the physical, mental and social factors that contribute to the well-being of the individual.[70] This social conception of health takes into account the basic needs of people and sees how they are important for personal health. Such things as safe environments, basic necessities (e.g. adequate food, shelter), basic amenities (e.g. transport, recreation, beauty, stimulation), safe, rewarding and meaningful work and companionship and involvement are judged to be significant.

The place of physical fitness in the lives of aged people is directly related to well-being. Minimising dependence has great financial consequences for the community. People of all ages benefit from regular physical exercise, but it is of particular importance to older adults. In recent years it has been recognised that, just as mental deterioration may be the result of not using one's mind enough, many of the physical

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[68] House of Representatives, *Expectations of Life…*, 103-110

[69] G.R.Palmer and S. D. Short, *Health Care and Public Policy. An Australian Analysis*, (Sydney: Macmillan, 1991), 248

[70] F. Ehrlich, "Health and Illness" in *Towards an Older Australia. Readings in Social Gerontology*, edited by A.L. Howe, (St.Lucia, Qld.: University of Queensland Press, 1981), 103

symptoms traditionally associated with aging are really symptoms of lack of exercise. Maintaining muscle strength, flexibility and cardio-vascular efficiency can mean the maintenance of the capacity for independent living and the ability to engage in activities which make that independence rewarding and useful.

General well-being is obviously affected deeply by physical well-being and options are available to intervene early to modify threats to physical well-being. It follows, therefore, that primary care will be a key concept in health policies for an aging population. For example, loss of bone mass is prevalent among women in their 80s such that by age 80 a third of women have suffered a fracture due to osteoporosis. Education about maintaining adequate calcium intakes is vital for preventing the effects of osteoporosis from becoming an increasingly disabling and expensive health problem. Many are pessimistic about the likelihood of preventing or curing some of the major chronic diseases and chronic conditions of old age, e.g. senile dementia, arthritis, arteriosclerosis, incontinence and depression. In Australia about 50 per cent of nursing home patients and 16 per cent of hostel residents suffer from some form of dementia. Incontinence is both a social and medical issue for the elderly. More effective prevention, treatment and management of incontinence offers great potential for restoring the dignity and independence of the older person, reducing both admission to a nursing home and, where this occurs, the duration of residence.[71] Formal national debate about health promotion and illness prevention has listed about five national health priorities for the 1990s, although both detail of the priorities and ways of ensuring action have been variable.[72]

The health status of the community gives rise to the questions: does increasing longevity mean more years of good health? Or, are people being kept alive longer while in poor health? Without doubt the health status of older people will be a significant determinant of their quality of life and their capacity to contribute to the community. Two comments are apposite here. It has been suggested that the improvements of life expectancy at older ages is historically unprecedented and the effects of this on the lives of the elderly is yet to be studied adequately. Secondly,

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71 Rowland, *Ageing…*, 102-104

72 The Health Targets and Implementation (Health for All) Committee report, *Health for All Australians. Report to the Health Ministers' Advisory Council and the Australian Health Ministers' Conference*, (Canberra: Australian Government Publishing Service, 1988) identified five national health priorities: injury, cancer, hypertension, nutrition and older people. This report followed on the work of the Better Health Commission, *Looking Forward to Better Health*, Final Report, vols. 1, 3 (Canberra: Australian Government Publishing Service, 1986). More recently the Department of Human Services and Health has published *Better Health Outcomes for Australians. National Goals, Targets and Strategies for Better Health Outcomes into the Next Century*, (Canberra: Department of Human Services and Health, 1994)

research already carried out indicates that age-specific morbidity rates have changed very little as the life expectancy of older people has increased of recent years.[73] Closely connected with the issues of mortality, morbidity and longevity is the issue of quality of life for elderly people. Reference has already been made to the impact of chronic and disabling illnesses in the lives of the elderly. Mobility and safety likewise contribute to the quality of an old person's life-style. Assured independence and an environment that enhances this are critically important for the health of the elderly. Among specifically medical factors one must also include the use of prescribed and non-prescription drugs for they have a definite bearing on the quality of life of many aged people.

The 1993 *Survey of Disability, Ageing and Carers* estimates that, among Australians over the age of 60, 1.4 million had a disability (constituting 44.2 per cent of all persons with a disability) and 1.1 million had a handicap (47.6 per cent of handicapped people).[74] Disabled older people living at home most frequently require assistance with home maintenance or transport.[75] The frequency of impairment, disability and handicap among the elderly has given momentum to the need for rehabilitative therapies in health care. Rehabilitation applies to

> the whole process of restoration of a person to the fullest mental, physical and social well-being, of assisting him/her to leave the institution and to live in dignity in the community. This has involved the extension of physical rehabilitation to the establishment of support services in the community and to the prevention of entry into institutions by the provision of community based treatment, restorative and supportive services.[76]

Rehabilitation of the elderly, therefore, has limited goals. It is directed to the independence of aged persons according to their capacity given the number of their years.

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73 Andrews and Carr, "Health Care...," in *Grey Policy...*, 113

74 A disability is *any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.*(The International Classification of Impairments, Disabilities and Handicaps definition). The WHO defines impairment *in the context of health experience,...[as] any loss or abnormality of psychological, physiological or anatomical structure or function.* A handicap is identified as a limitation to perfom certain tasks associated with daily living. The limitation must be due to a disability and in relation to one or more of the following: self-care, mobility, verbal communcation, schooling, employment. Cf. Australian Bureau of Statistics, *Disability, Ageing and Carers Australia 1993. Summary of Findings*, (Canberra: Commonwealth Government Printer, 1993), 52-55

75 Australian Bureau of Statistics. *Disability...*, 8-10. Cf. Rowland, *Ageing...*, 90-94

76 B. Ford, "The Rehabilitation of Older People" in *Towards an Older Australia. Readings in Social Gerontology*, edited by A. L. Howe, (St. Lucia, Qld.: University of Queensland Press, 1981), 164

1.5.2 Health Care for the Aged

1.5.2.1 Dimensions of Health Care

The development of health care facilities through history will be considered in greater detail later in this thesis. Here it suffices to note that in Australia, in nineteenth century New South Wales, care of the needy was organised by the Benevolent Society of N.S.W., with the whole complex of values the name of the Society implies. By the beginning of this century hospitals focused their attention on the sick and in time separate facilities were set up for different needy groups such as orphans, the blind, deserted women, spastics etc. The process of *cluster identification* and the development of eligibility criteria for access completely overlooked the elderly who were to be found in each of the needy groups. It is only in comparatively recent times that the elderly have been identified as a distinct group to be cared for in their own right.[77] Two observations are pertinent in the light of this development. First, it has been primarily the forces of social change that have shaped the types of services that have developed in the Australian context. Second, early undertakings by voluntary and charitable associations of the care of the needy and later involvement of governments goes some way to explain the conflicting forces at work, even today, in the delivery of health care and community services to the aged.

Two further developments are important here. The first entails the development of geriatrics and gerontology in this country. Gerontology is the inter-disciplinary study of human aging.[78] Geriatrics refers to "the medicine of later life, in particular the medicine of old age, where we observe not only the emergence of new diseases (diseases not seen at younger ages), but also chronic (long-lasting) disorders, the cumulative adverse effects of *normal* ageing, and changes in the way diseases and injuries generally present themselves in the context of an ageing body (and person)."[79] Both disciplines were little heard of in Australia before 1960. The word *geriatrics* was coined in the early part of this century from two Greek words, *geron*, an "old man" and *iatrikos*, "medical treatment". Even as late as 1988 Australia had only about one hundred geriatricians, about half of whom were in full-time practice.

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[77] Ford, *The Elderly Australian*, 73-81

[78] Gerontology is a "field of scientific study that examines the biological, medical, and psychosociological processes of aging. The field of gerontology is also concerned with the well-being, care, and treatment of the elderly and extends to geriatric health care." G.R. Martin and G. T. Baker, "Aging and the Aged. I. Theories of Aging and Life Extension" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 1, (New York: Simon & Schuster Macmillan, 1995), 85

[79] D.B.Bromley, *Behavioural Gerontology. Central Issues in the Psychology of Ageing*, (Chichester: John Wiley, 1990), 9

The Australian Geriatrics Society estimated conservatively that an additional one hundred and twenty five geriatricians were needed at that time. In a health care system that favours curative medicine medical care of the elderly is not an attractive career option for many medical students. The dearth of specialists in this field has a direct impact on the availability of geriatric assessment and its use in determining access to residential care. Health care of the elderly is dependent to some extent on the attractiveness of this form of medicine within the medical and wider health care environment.[80]

The second development that has had an enormous influence on health care for the elderly is the increased medical specialisation that has resulted in the *medicalisation* of old age. This has contributed to the perception that the inevitable features of old age are illness, frailty, weakness and uselessness. The resulting underestimation of the capabilities of aged people has caused a paradoxical situation where "the conditions which society ascribed to the ageing process are in fact partly due to the inactivity society encourages in older people."[81] An aging society is now requiring health care to re-align its priorities. In place of a health care system focusing on the cure of short-term, episodic illnesses in a younger population emphasis will need to be given to less severe but chronically ill aged persons who experience long term and often incurable conditions. The implications of this for future health care of the aged will be its *de-medicalisation* and a greater emphasis on *care* and *quality* of care in all sectors be they institutional or community based.

1.5.2.2 Health Care Services, Funding and Policies

A brief review of literature of the last twenty years indicates a broad consensus approach to health care for the aged. Many writing in the area argue strongly for an integrated approach to the elderly.[82] Complementary medical and hospital services, specialist medical referral services, specialist geriatric units and community services in an integrated network appear to be the future shape for health care delivery to the elderly.[83] The complementary services and the integrative network both raise questions about health care expenditure.

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[80] Rowland, *Ageing…*, 101-102

[81] House of Representatives, *Expectations of Life…*, 114.

[82] Cf. Ford, *The Elderly Australian*, 81-125; G.C. Hughes, "Health Services for the Aged" in *The Aged in Australian Society*, edited by S.Sax, (Sydney: Angus and Robertson, 1970), 103; Ehrlich, "Health...," in *Towards an Older Australia…*, 110-116

[83] Andrews and Carr. "Health Care...," in *Grey Policy…*, 116-121

Any analysis of health care expenditure on the aged is limited, it is claimed, by inadequate information.[84] Health expenditure rises significantly with age. Over 70 per cent is publicly funded in Australia. In 1989-90 public outlays on health care for the aged were comparable to the expenditure on aged pensions.[85] While aged persons are approximately 10 per cent of the population they absorb 39 per cent of health care expenditure. Per capita expenditure on persons over 65 years of age is six times more than that on people below that age level. For those over age 75 almost half of health expenditure is spent on the 13 per cent who die within two years. Expenditure on the rest of the over 75 year and older persons is only 2.7 times the average for the population as a whole.[86] Strategies to contain the costs of hospital care for the aged include (1) reducing inappropriate use of acute beds by elderly patients who could be cared for adequately in less expensive geriatric or convalescent wards and (2) reducing hospital stays where community nursing is able to provide suitable support.[87] It is a myth, however, that escalating costs associated with care of aged people is explained solely by the fact that they are an increasingly large proportion of the population. As Palmer and Short argue

> increasing costs associated with the aged are linked more closely with social and political changes than physiological ageing as such. Political changes include increased government financial support for nursing homes, and social factors include compulsory retirement, and higher rates of women's workforce participation.[88]

Any detailed analysis of health care costs for the elderly must necessarily go beyond a consideration of expenditure on Medicare benefits.[89] Among a number of complicating factors are the division of responsibilities, ongoing conflicts and costs-shifting that exist between Commonwealth, state and local governments. Further complicating this state of affairs is the involvement of the private and voluntary sectors in aged care. Furthermore, the topsy-turvey nature of Australian health care in

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84 Andrews and Carr. "Health Care...," in *Grey Policy...*, 114

85 Clare and Tulpule, *Australia's Ageing Society*, 35

86 Clare and Tulpule, *Australia's Ageing Society*, 39

87 Rowland, *Ageing...*, 99

88 Palmer and Short, *Health Care...*, 249

89 Medicare is a national health insurance scheme available to all Australians which provides a substantial proportion of the cost of all services given by doctors and guarantees access to public hospital services. There are associated programs such as the Pharmaceutical Benefits Scheme involving a greater proportion of co-payment and a scheme of universal provision of nursing home care and hostel accommodation for the elderly based on medically certified need. Medicare is regarded in Australia as a national health scheme and is universal. In this it differs from the American Medicare and Medicaid programs which differentiate between the poor and the elderly. The Australian health system, costing approximately 8.5% of GDP, differs from its American counterpart which absorbs 14% of GDP.

general must be appreciated. Andrews and Carr argue that it has "developed in response to (and largely been implemented by) the demands of private medical practice, the hospital industry and nursing home enterprises more than the needs of older people."[90] The consumer was, initially, relatively powerless. More recently, however, consumer advocacy in all its forms has entered as a significant contributor to the development of the health care agenda.[91] Finally, the fee-for-service approach in funding is more suited to cases of acute illness. It is less suitable where chronic and disabling conditions are being treated. Thus the funding regime itself is a disincentive to adequate health care delivery for the elderly.[92]

Policies underpinning provision of health services to the aged, particularly medical and hospital services, are frequently implicit rather than clearly articulated. More recently, however, government agencies have made their policies more explicit. Nevertheless, multiple spheres of government, private and public providers and various institutions have been involved, but the resulting policies and organisation of services, have been disjointed rather than integrated. This reflects the complexity of the Australian health care system. The result has often been an overlap of program objectives, multiple regulatory and financial arrangements, and confusion over responsibilities and accountability for delivery of care.

A significant aspect of aged care in this country is the high rates of institutional care of the elderly. A contributing factor to this phenomenon has been the proliferation of nursing homes following the introduction of the Commonwealth government subsidy in 1962. Among the continuing problems of institutional care of the aged is that "there are a large number of aged people with chronic long-term health problems placed in acute care hospitals instead of nursing homes, and the presence of aged persons in nursing homes due to factors such as lack of alternative accommodation and community services."[93] It is to this issue we now turn.

1.5.2.3 Institutional Care for the Aged

For the elderly who are sick two things follow. First, they require a more complicated array of resources than do the young and very often the burden of their illness is multiple in nature. Second, the historical evolution of health care, and particularly health care for the aged, has resulted in a disproportionate use of institutional care.

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90 Andrews and Carr. "Health Care...," in *Grey Policy...*, 123

91 Such groups as the Council on the Aging Australia and the Consumers' Health Forum of Australia have been at the forefront of developments in the area.

92 Andrews and Carr. "Health Care...," in *Grey Policy...*, 124

93 Palmer and Short, *Health Care...*, 250

Acute care hospitals very often house elderly people with chronic long term ailments and nursing homes are being forced to undertake the role of hospices within retirement villages. Widespread institutional care of the aged in Australia may be traced to the 1962 Commonwealth subsidy for nursing homes. The McLeay Report recognised this to be the case, attributing it to complex and interrelated forces of a financial, bureaucratic and political nature.[94] Anna Howe, who advised McLeay, goes further when she points out that "(s)hifts in the way in which nursing home care has been viewed in the policy process are . . . attributable not so much to actual changes in the provision of nursing home care or the needs of the aged, but rather to changes in the conceptualisation of the issues over time."[95] Observing the interests of different groups involved in the debate Howe noted that each group brought particular conceptualisations of the problems involved. As the groups participated in the policy process, and the balance of power between them changed, so the issues and the nature of the debate also changed. She rightly observed that the impact of nursing home policy on the aged population was much more restricted than was the government's income support policies which affect virtually the entire aged population. It should be noted as well that the way nursing homes came to be funded created an emphasis in favour of institutional care. Whether the process adequately addressed the needs of the elderly in the population is another question.

Four phases have been identified in the development of nursing home policies in Australia: (1) laissez-faire policy (1963 to early 1970s); (2) policy by regulation (up until the late 1970s); (3) redefining the issues (from late 1970s to 1982); (4) restructuring (from 1983 onwards).[96] During the laissez-faire period few policy decisions were made directly about nursing home care. The system evolved as a side-effect of decisions made in other health care areas particularly in the area of health insurance. Once a nursing home industry developed then it became a sector concerned with its own survival. Administrative short-comings in nursing homes provoked federal government intervention. From 1973 onwards controls were exercised over admissions, growth and fees. The focus of concern during the 1970s was the administration of nursing homes. This, too, came under increased scrutiny. The process of redefining the issues connected with nursing homes began with the McLeay Report (1982) and came to the fore with the report of the Senate Select Committee on Private Hospitals and Nursing Homes (1985). "The entry of

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94 House of Representatives *In A Home Or At Home…*, 50

95 A.L. Howe, "Nursing Home Care Policy: From Laissez-Faire to Restructuring" in *Grey Policy. Australian Policies for an Aging Society*, edited by H. L. Kendig and J. McCallum, (Sydney: Allen & Unwin, 1990), 151

96 Howe, "Nursing Home...," in *Grey Policy…*, 152-167

representative advocacy groups and alliances of professionals and their clients into the policy process introduced new perspectives on many issues and was especially influential in bringing issues of standards to the fore."[97] Howe suggests that the public debate was advanced by the work of professional bodies such as the Annual Conference of the Australian Association of Gerontology and an increase in research studies. Restructuring the relationship between residential and community care of the aged occurred on a number of fronts. Reorganisation of the bureaucracy, especially through the establishment of the Department of Community Services and the Office of the Aged, together with administrative initiatives, e.g. the Home and Community Care Program, development of geriatric assessment units and the Nursing Homes and Hostels Review (1986), are a number of the initiatives now under way at the federal government level. The bureaucracy is now seen to be a key player in the development and implementation of policy for aged care. This brief summary points to the maturing of aged care as an issue and its place in the mainstream policies of government.

1.6 COMMUNITY SERVICES AND THE AGED

Very little has been written about community services as a distinct policy field.[98] In spite of this gap in the literature there seems to be general agreement that (1) elderly people should be assisted to remain in their homes and (2) institutional care should be a last resort.[99] The grounds for this are both humanitarian and economic. As the dimensions of community care are explored in what follows two questions ought be kept in mind: First: is the focus of community care primarily on retaining the elderly *in their own homes* or *in the community*? Second: does the emphasis on *de-institutionalisation of care* where possible have implications different from use of institutional care *as a last resort*?

1.6.1 Community Care: Its Evolution and Providers

Until the end of the Second World War community services for the aged were not significant. Elderly people were categorised as either *pensioners* or *patients*. Lobby

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97 Howe, "Nursing Home...," in *Grey Policy...*, 161

98 J. Healy, "Community Services: Long-Term Care at Home?" in *Grey Policy. Australian Policies for an Ageing Society*, edited by H. L. Kendig and J. McCallum, (Sydney: Allen & Unwin, 1991), 127

99 Kendig and McCallum, *Greying Australia...*, 50

groups for pensioners, senior citizens associations etc. evolved during the 1950s. At the same time *meals-on-wheels* and *home help* began to be offered. A degree of ambiguity existed at the time regarding the claim for assistance older persons had on the community generally. Judith Healy indicated three grounds justifying services to the aged that have been proposed during the last fifty years. The first approach regards age as irrelevant: the needs of elderly people should be addressed within existing mainstream services. The second approach redefined old age upwards to 75 years and beyond. The third viewed old age as *veteranship* with the implication of earned status.[100] Because of this confusion and the conflicting attitudes to community services elderly people have been disadvantaged. Unlike the old age pension

> eligibility and entitlements to community services are poorly defined and discretionary. The adverse consequences are, first, that the power of the provider is increased and that of the consumer diminished, and second, that the uncertainty and limits of community services may incline the elderly to seek the security of institutional care.[101]

In discussing community services a distinction must be drawn between those offered in the home and those outside the home. Services in the home include: house cleaning; delivery of prepared meals; personal and health care; home nursing; minding and respite care; monitoring; friendly visits; personal aids and appliances; laundry; shopping; gardening; house repairs and maintenance; house adaptations; security systems and mobile libraries. Services offered away from the home include senior citizens centres and clubs; day care centres; day hospitals; recreation and exercise programmes; education courses; outings and holidays; concessions; transport; respite care; information; counselling; financial and legal advice; paramedical services such as physiotherapy, podiatry, occupational therapy, dietetics and speech therapy; geriatric assessment.[102]

The family, paid help and publicly funded services constitute the main providers of community based services to the elderly.[103] The burden of providing help to the aged at present falls overwhelmingly on the family. The family has a crucial place in the life of the aged person. Hal Kendig asserts that "family bonds - especially with a spouse and children - are the primary avenue for social integration in old age."[104] Furthermore, it is the family which is the connecting point between all generations in

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[100] Healy, "Community Services...," in *Grey Policy...*, 131

[101] Healy, "Community Services...," in *Grey Policy...*, 131

[102] Healy, "Community Services...," in *Grey Policy...*, 128

[103] Kendig and McCallum, *Greying Australia...*, 51-53

[104] H. Kendig, "Ageing, Families and Social Change" in *Ageing and Families. A Support Networks Perspective*, edited by H. L. Kendig, (Sydney: Allen & Unwin, 1986), 172

the life cycle. The pivotal role of the family as a source of support in later life has been asserted frequently in gerontological literature. The family, it is argued, balances the segregation of old people that occurs because of formal economic, social and political structures of industrial society by integrating them into primary networks of mutual affection and care. Within industrial societies the aged are able to survive only because of the psychological and other supports given them by their families. Absence of family ties is seen as a significant factor contributing to the casualties of old age, viz., the institutionalized and the lonely.[105] Paid assistance functions primarily in the areas of transport and jobs around the house. It is in these two areas that the elderly frequently have unmet needs. Through payment for these services they remain in control and are not thereby put under obligation to others. The financial situation of the elderly will dictate access to these services. Basic inequalities in access to transport have an obvious and direct impact on the their quality of life. Assistance in the form of meals-on-wheels, home help and the visiting nurse originally developed in response to the needs of the elderly in the local area. Subsequently the services were absorbed into the Home and Community Care scheme which will be discussed in more detail below.

1.6.2 Family Care of the Elderly

Aged families are structurally diverse. Married couples maintain their household independent of adult children for as long as they can. The unmarried and widowed, on the other hand, follow no one pattern.[106] Any research into aging must take account of the social patterns of the Australian family and should include qualitative as well as quantitative research.[107] It is important to note here that "ageing is as much a social construction as a biological fact".[108] The social influences on aging are significant for this study. How the aged person negotiates the transitions into and through the stages of old age is central to his or her well-being.[109]

Family members support their aged parents and relatives in a variety of ways, e.g. by direct and indirect economic help, caring for them when they are sick, taking them

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[105] Cf. C. Swain, "Family Roles and Support" in *Towards An Older Australia. Readings in Social Gerontology*, edited by A. L. Howe, (St.Lucia, Qld.: University of Queensland Press, 1981), 205

[106] Swain, "Family Roles...," in *Towards An Older Australia...*, 205

[107] Research findings of the Australian Institute of Family Studies are a significant resource in this area.

[108] H. Kendig, "Ageing, Families and Social Change" in *Ageing and Families. A Support Networks Perspective*, edited by H. L. Kendig, (Sydney: Allen & Unwin, 1986), 170

[109] Cf. M.d'Apice, *Noon to Nightfall. A Journey Through Mid-Life and Ageing,* (Melbourne: Collins Dove, 1989), 158-176

shopping, etc. In addition they fulfil within the family context important emotional needs of affection and self-expression. The supportive role that same-age friendships play in the lives of elderly people must, however, not be overlooked. Such an oversight may occur when a too narrow view of the role of the family in the lives of the elderly is assumed.

A number of social factors influencing the family's care of an aging member must be considered.[110] The faster pace and multiple commitments of modern life make for greater difficulty in the family offering support. An adult daughter with her own family is more likely than not also in the workforce. She is required to juggle the competing demands of job, home and care of aged parents. Increasingly the demand for assistance will be heaviest when the elderly parent or relative is in the *old*-old category. It is at that time that the adult daughter is nearing retirement herself. The long-term influence of divorce and blended families on family patterns and relationships has still to emerge. Nevertheless, such changing patterns will have an impact on the types and quality of care families extend to their elderly members.

1.6.3 The Political Context of Community Care

The McLeay Report in 1982 spoke of *home care* as the alternative to *institutional care*. At that time one feature of the domiciliary sector was its disorganisation.[111] To some extent this was due to the fact that community services in Australia had developed through independent voluntary agencies which were distinct from the institutional care networks of elder care.[112]

Responsibility for services to the aged continued to be dispersed through all three levels of government, voluntary agencies and private sector initiatives.[113] The particular complexity of the relationships within the public sector in community care is indicative of the more basic issues of Australian federalism. Commonwealth governments view care of the aged as a national responsibility. Redistributive policies across states and between population groups is a primary concern for the federal government. This frequently conflicts with the states and their agenda. While

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[110] Cf. J. McCallum and A.L. Howe, "Family Care of the Elderly in Australia" in *Family Care of the Elderly. Social and Cultural Changes*, edited by J.I. Kosberg, (Newbury Park, Ca.: Sage, 1992), 159-178

[111] House of Representatives, *In A Home Or At Home…*, 84

[112] Healy, "Community Services…," in *Grey Policy…*, 134

[113] This is exemplified by Anna Howe, "Organization and Utilization of Community Services in Melbourne" in *Towards An Older Australia. Readings in Social Gerontology*, edited by A.L. Howe, St. Lucia, Qld.: University of Queensland Press, 1981, 179-182

devolution of responsibility to the states may be more efficient the federal government is unwilling to hand over funds unless its policy goals are achieved. The states resist this approach fearing insufficient funds will be provided to do the job.

> There are conflicting incentives for state governments in developing community services: on the one hand it is cheaper for the states when their dependent elderly populations use Commonwealth-subsidised nursing homes rather than cost-shared community services; on the other hand, health costs are the major item in state budgets and a well-developed array of community services might reduce the hospital stays of the elderly who account for a major proportion of hospital beds. Some elderly inpatients could be discharged home earlier if home nursing and personal care were available.[114]

Local government and voluntary agencies contribute a substantial yet uncosted amount to community services. These groups consider that government policies exert an influence disproportionate to the government's financial contribution.

1.6.4 The Home and Community Care Scheme and the Aged Care Reform Strategy

Since the McLeay Report in 1982 it has been generally agreed that the problems identified in the provision of accommodation and home care services for the aged can be best overcome by establishing an integrated framework for future developments. Such a framework would also provide a time-table for planning and implementation of changes.[115] This proposal, together with the *Nursing Homes and Hostels Review* of the Department of Community Services in 1986, provided the impetus for the enactment and implementation of the *Home and Community Care Act, 1985*. This Commonwealth-state program, referred to as HACC, subsumed the services provided by four previous Acts of Parliament. The program came into being with the 1984-85 budget with the announced intention of substantially improving the quality and range of services available to the frail aged and to younger persons with disabilities living in the community. The range of community-based services available previously was relatively limited and poorly coordinated. Projects had received government funding under different Acts and under a mix of direct and joint funding arrangements.[116]

The frail aged and younger disabled persons targeted by HACC were judged to be at risk of premature or inappropriate admission to long-term residential care. Carers of these persons were also included in the program. The program sought to provide a

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[114] Healy, "Community Services...," in *Grey Policy...*, 135

[115] House of Representatives, *In A Home Or At Home...*, 106

[116] Mathur, *Aged Care...*, 11

comprehensive range of integrated services made available either in the person's home or in community based centres. The types of services eligible for funding under the program are: home help and personal care; home maintenance and modification; food; respite care; transport, paramedical services; home nursing; assessment and referral; education and training for service providers and users; information; and coordination. Although community services were advocated as a means of sustaining the social integration and autonomy of the aged another expectation was that community services would prove to be a less expensive means of providing support to the growing number of frail persons in an aging population.[117]

Costs have continued to be a preoccupation with the HACC program. Out of the total increase of $460 million for aged care between 1985-86 and 1990-91, about one-third was for HACC programs, a *100 per cent increase in real terms.*

> This expansion has sustained four main changes in use of community services: increases in the client population due to growth of the aged population; increases in cover, that is, in the proportion of the potential client population using services; increases in the level and range of services used especially by clients with complex care needs; and increases in provision in areas previously lacking services.[118]

HACC programs now account for 14 per cent of Commonwealth expenditure on aged care. Local involvement is judged, by central planners, to be at the cost of a comprehensive or uniform coverage of groups in the community in need. An added difficulty is provision of integrated services that respond to the range of an individual's needs.[119]

The legislation enabling HACC is noteworthy for its criterion of application shifted from *age* to *needs*. The resulting incorporation of the disabled young with the elderly has had significant consequences. Increased competition for scarce resources has resulted and community service agencies which have traditionally served the elderly must now respond to younger disabled people. Disability is now defined in terms of *behaviour* rather than a *medical condition.* Focus is on the support and assistance required to perform daily living tasks.[120] Risk of long-term residential care is the central criterion of eligibility for HACC assistance. This eligibility requirement must

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117 Rowland, *Ageing...*, 203

118 Commonwealth Department of Health, Housing and Community Services, *Aged Care Reform Strategy. Mid-Term Review. 1990-91*, (Canberra: Australian Government Publishing Service, 1991), 185-186

119 Clare and Tulpule, *Australia's Ageing Society...*, 80-81

120 Healy, "Community Services...," in *Grey Policy...*, 136

be viewed in the context of the Commonwealth's efforts to restrict availability of nursing home beds to those in need of full-time nursing care.

The HACC program began slowly, impeded by a number of preexisting obstacles e.g. the manner of Commonwealth and state funding arrangements, a diversity of service delivery methods in the different states etc.[121] In the light of the mid-term review of HACC a number of comments about its implementation are appropriate.[122] The *Mid-Term Review* charted the reform of aged care programs from 1986 to 1991 and proposed the direction to be taken during the next five year period. The review sought to evaluate whether the program of reform was on course and reported that significant outcomes had been realised in equity, access and participation. The judgment on this was to be made in light of the Labor government's Social Justice Strategy. The aged care reform strategy initiated by HACC was, as noted above, directed to changing the balance between residential care and community services in favour of the latter. The key to the strategy was the notion of *balance of care*. This refers to the mix of care services available to the population of a defined area together with the level of resources required. It was recognised that considerable variations in the balance of care existed from region to region. It was hoped that where a good balance was achieved this would offer a guide to improvement in other areas.

The Report gives ample evidence that both policy and implementation issues were central in the process of evaluation. Recommendations for the future indicated the priorities for aged care during the years to follow. These merit mention here. The report sees a need for

- an integrated framework for planning and financing aged care;
- development of *benchmarks* for community care;
- discernment of resource requirements ensuring equitable and efficient allocation of resources;
- recognition of the impact on the balance of care from other closely associated areas such as housing and acute health care;
- assessment of services which give priority to high dependency clients;

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121 Healy, "Community Services…," in *Grey Policy…*, 136-140

122 Commonwealth Department of Health, *Aged Care Reform Strategy. Mid-Term Review. 1990-91.* Anna Howe had a significant input into the Review. This must be taken into account when judging the merits of the report.

1.7 SUMMARY AND CONCLUSIONS

1.7.1 Summary

Chapter 1 has presented a range of details sufficient to understand the issue of health care for aged Australians. Initial consideration of the question of aging and the human experience of senescence introduced relevant demographic facts about Australia as an aging community. This data is basic for the issues canvassed in the remainder of the chapter. Employment, work and retirement increase in importance as people grow older since all three have a direct impact on retirement income and the financial status of the elderly. The domestic needs of aging persons, the types of accommodation they use and the political dimensions of housing arrangements were next discussed. A consideration of the health that elderly persons enjoy provided a context for understanding Australian health care and its services. Three particular areas are of relevance here: funding for health care, policy development and institutionalised care of the aged. By the early 1990s care of the aged was being given a higher priority through community based care such as the Home and Community Care program.

1.7.2 Conclusions

1.7.2.1 The Elderly Person

The dominant paradigm underlying most of the demographic, economic, housing, health and community care dimensions of aging explored in the course of this chapter is that of age-as-chronology. While every effort is being made to remove discrimination by age from public life the use of chronological age remains the most basic criterion in many areas. Little or no attention appears to have been given, in the literature canvassed in this chapter, to the subjective dimensions of aging: awareness of passing time, the experience of increasing limitation and of loss, awareness of mortality. It will become an important concern of chapter 2 to explore some of these questions of meaning that cluster around the experience of aging in contemporary Australia.

In a number of areas self-reliance in the basic areas of daily living has been assessed as a criterion of human dignity for the elderly Australian. This fits closely with the liberal individualism of contemporary society, with its legal and philosophical preoccupation with autonomy and freedom of choice. As persons age, however, the autonomy and choice characteristic of an active adulthood tend to confront the realities of increasing degrees of dependence. These important dimensions of the human journey remain unresolved in present day Australian aged care.

Attention to function and capacity in the lives of the elderly is laudable. Care that encourages rehabilitation when function and capacity are absent must also consider other dimensions of the human person. A society where youthful bodily beauty and active sporting involvements are prized finds some difficulty with the cultural, spiritual and emotional dimensions of human life. These are elements that need somehow to be part of the care of aged members of our community.

1.7.2.2 The Community of the Elderly Person

Several times in this chapter reference was made to age as a social construct. This raises the fundamental question of the meaning of aging in Australian society. Part of the confusion in public policy and the efforts to extend care to the aged as an integral part of the population may hinge on the fact that there is no consensus as to the meaning of growing old. This vision of old age confronts a work ethos in our society that values employment and productivity as *the* criteria of individual identity. Discussion of disengagement theory and dependency ratios all have the issue of productivity lurking in the background. When, through the passing of the years, an individual leaves the workforce and may experience periods of dependence, either financially or because of ill-health, it becomes obvious that a coherent and meaningful vision of old age is needed. The aged person is often judged to be a burden, a nuisance and even eligible to be eliminated, as indicated by current proposals to legislate for euthanasia.

A pervading aspect of aged care policies throughout this century in Australia has been a concern for social justice and a basic standard of living. Pension incomes have also been seen as a safety net for the less well off in the community. Quality of life has also been a consideration with home and community care. The social justice dimension of many aged care policies is an important element in the Australian scene. This factor must be borne in mind throughout the course of the thesis, especially as this emphasis is lacking in much American literature.

The reciprocal relationships elderly Australians have with other members of their family and with their peers provide a significant social fabric against which to judge aged care policies in this country. The social change in Australian family life raises some of the gravest issues for consideration since the effects on the family of single and multiple family breakdowns have yet to be evaluated for their influence on elder care.

1.7.2.3 Responding to Old Age in Australia

The shift from an age to a need criterion in the delivery of home and community care has been an important one. Need, as we will see later, is an elastic notion. An uncritical concentration solely on need may, in time, cause a conflict between particular groups within our society, as has occurred with intergenerational conflicts in the U.S.A. Considerable effort will need to be given to defining the basic needs that society accepts as being its responsibility.

A coherent aged care policy has been slow to develop in this country. What has become obvious through this chapter is the comprehensive and inter-locking nature of the range of issues involved. Aged care for Australians must be seen as a tapestry of connecting issues. The most important have been analysed in this chapter. If and when a coherent aged care policy develops many partial responses to the needs of the aged will be adequately implemented.

CHAPTER 2

PROBLEMATIC QUESTIONS: HUMANISTIC REFLECTION

2.1 Aging: What Does It Mean to Grow Old? 60

2.1.1 The Experience of Growing Old 60
2.1.1.1 The Experience 61
2.1.1.2 The Meaning of the Experience 63
2.1.2 Explaining the Experience of Growing Old 66
2.1.2.1 A History of the Attempt 66
2.1.2.2 The Normative Life Cycle 70
2.1.2.3 The Natural Life Span 74
2.1.2.4 Scientific Explanations of Aging 77
2.1.2.5 Sociological Explanations of Aging 77
2.1.2.6 The Ethical Meaning of Aging 79
2.1.3 Implications for Just Health Care 79

2.2 Well-Being: What Does it Mean to be Healthy or Ill? 80

2.2.1 Experiencing Health and Illness 81
2.2.2 Explaining the Experience of Health and Illness 85
2.2.2.1 Health 85
2.2.2.2 Illness, Disease and Sickness 87
2.2.3 Implications for the Aged 91

2.3 Care: What Does it Mean to Care? 94

2.3.1 The Experience of Care 95
2.3.2 Explaining the Experience of Care 97
2.3.2.1 The Notion 97
2.3.2.2 History 98
2.3.2.3 Medical Care 100
2.3.2.4 An Ethic of Care 101
2.3.3 Implications of Care 106

2.4 Summary and Conclusions 111

2.4.1 Summary 111
2.4.2 Conclusions 111
2.4.2.1 About Aging, Well-Being and Care 111
2.4.2.2 About Justice 113
2.4.2.3 Future Directions 114

CHAPTER 2

PROBLEMATIC QUESTIONS: HUMANISTIC REFLECTION

Chapter 1 outlined the evolution of aged care policies in Australia during the century to 1991. The comprehensive and interconnecting nature of the different facets of aged care was explored in some detail. The exposition made clear the ways in which many of the policies have developed reactively, in response to a variety of pressures within the society. Preference for technical responses and pragmatic solutions to the many issues confronting the elderly has characterised Australian aged care policies. The future would appear likely to bring more reactive responses and technical fixes because there is a radical failure in late-20th century Australian society to name, delineate and explore the profound human issues that aging brings both to individual citizens and to the body politic. These issues must be analysed if this nation is to develop a realistic, comprehensive and satisfactory set of policies that will mediate a just health care to all elderly Australians.

A pastoral or humanistic view of aging raises questions whose answers offer an understanding of aging that is much more richly textured than many of the approaches canvassed in the preceding chapter. An analysis of just health care for its aged requires Australian society to confront fundamental questions of meaning. Three *meaning* questions dominate this chapter. As aging persons become greater in number and a greater proportion of the total population, the issue of growing old has both personal and social immediacy. "What does it mean to grow old?" invokes a range of philosophical and theological issues that have direct consequences for the justice and health care delivery questions that are of central concern throughout the following chapters.

Two further questions follow from the initial inquiry into the meaning of aging. This thesis is exploring justice aspects of health care for elderly Australians. Health and illness have different dimensions throughout the life course. For the elderly in particular the limitations of aging may require an understanding of health and illness different from that experienced by the same individual during youth, young adulthood or middle age. Hence, the second question that must be asked is: "What does it mean to be healthy or ill?" When old age brings limitations and dependency, the understanding of care assumed in health and welfare services requires deeper analysis and consideration. This third *meaning* question, "What does it mean to

care?" forces a consideration of the underlying expectations persons have of one another, particularly in times of personal limitation and vulnerability.

I argue that all three questions are central to any analysis of just health care for aged Australians. Failure to address such basic issues deprives current analyses of understandings that are essential for elaborating a satisfactory notion of justice and health care for the aged.

Each of the three areas of *meaning* will be explored by asking the same three questions. First: "what is the human experience of growing old, of being healthy or ill, or caring?" Common human experience provides the springboard for more detailed consideration and deeper analysis. At an existential level each individual person experiences senescence, as does a society self-consciously growing older. The same can be said of the experience of health/illness and care. Once this experiential dimension has been pondered it is possible to undertake a more systematic reflection on aging, health and illness and caring. The second question, "how is this experience explained?", offers an opportunity to explore the range of explanations offered through history and by the different disciplines of human knowledge. All of this, however, remains simply the musings of a disengaged philosopher unless it has some purpose. For that reason the third question: "how are the experience and the explanations significant for the central issues of this thesis?" provides a connection with the matters to be outlined in the chapters to follow.

Chapter 2 concludes with a brief consideration of the way questions of justice are implicit in the issues of Australian aged care canvassed in chapter 1 and the three meaning questions explored in this chapter. This provides a conclusion for Part I of the thesis and a springboard for the philosophical and theological analyses of just health care for the aged that follow in Parts II and III.

2.1 AGING: WHAT DOES IT MEAN TO GROW OLD?

2.1.1 The Experience of Growing Old

The experience of aging in the developed countries of the West occurs in societies permeated with a fear of death. Social attitudes view aging as a period of non-productivity. The priority given to all things technical considers aging as a pathology, the incurable disease of living. Growth and development, the dominant paradigm of life in the modern world, are portrayed primarily in terms of an increasing

independence. In this world aging is viewed as decline and a downward spiral into dependency. In reality, however, growth and development occur in an expanding system of obligations and dependencies. In this view, aging is but one of many stages in life in which all persons move through one system of dependency to another.[1]

2.1.1.1 The Experience

The understanding of aging first emerges in the life of each person as a temporal concept, as the transition from the past to the present to the future. Aging comes as something external to the self, impinging on the reflective subject as something from the outside, as foreign. In so doing it invokes concern. Response to this imposition of aging can be a free one, but our freedom necessarily must take the limited forms of either consent or denial, care or self-preoccupation. From a phenomenological perspective, knowledge of aging comes to us primarily as a witness mediated through the external world. There is direct testimony of aging in our immediate experience, but the signs are ambiguous. It is particularly because knowledge of our aging comes to us primarily as something external to our immediate experience of ourselves that awareness of aging is so easily denied. Aging seems to come to us from the outside as the future possibility of indefinite forms of decline and eventual death.[2]

As the human becomes old some parts of the body become rigid and others flaccid. Perhaps the hardening is a final structuring, a settling on what one's character and essence are to be, once and for all. The softening entails a dropping away of what one decides is not to be incorporated into the essential structure, the completed character. This does not mean that aging is not a time of growth. It is a growing clearer and more decided about the essence, the form, that one wants one's existence to have, a growing firmer in those features that will be the defining shape of the person.

At another level the experience of aging comes with the experience of slowing down. Associated with this is a different sense of time. Aging is the part of our lives in which our being slows on all levels: it enables the individual to experience situations and persons with more attentiveness and care. This is less likely to occur in earlier years when a youthful, fast-paced metabolism and an energetic, vigorous body inspire us to cover great distances at high speed and to finish quickly with one experience in order to hasten on to the next. It may well be that the elderly person realises that time has a dimension of depth as well as duration. Aging persons slow

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1 D.C. Thomasma, "Professional and Ethical Obligations Toward the Aged", *The Linacre Quarterly* 48:1 (1981): 74-75

2 D.S. Browning, "Preface to a Practical Theology of Aging" in *Toward a Theology of Aging*, edited by S. Hiltner, (New York: Human Sciences Press, 1975), 154-155

themselves to explore experiences, not in their linear pattern of succeeding one another, but in their possibility of opening for them entire worlds in each situation and in each person encountered. The aging person comes to be more gentle with these experiences, to take care to let their possibilities, their rich density emerge. The elderly continue moving through time, but they also move into time, allowing it to expand in depth even though its objective duration diminishes.

As one ages skin wrinkles and roughens, posture becomes curved. Memory is restructured, formerly unbroken stretches of clarity are marked by peaks and between them hollows called confusion.

> It is as though, through these changes, body and mind express the greater intricacies, the finer articulations that are possible in the person for whom reality has become many-layered, folded upon itself, woven and richly textured, a reality no longer ordered in the more familiar linear fashion, but now a world filled with leaps, windings, countless crossings, immeasurably more intricate and perhaps also more sure than the world of one-dimensional thought and self-evident distinctions.[3]

Among all these changes and indicators of aging, ambiguous as they are to the consciousness of the aging person, death is foreseen. One more meaning of aging, then, recognised experientially, consciously or not, is that life is finite. The sum of all these changes in aging perhaps indicates a tacit, organic knowledge that death is a reality, that *my* death is not something speculative but a *felt* reality in the very fabric of *my* existence.

The experience of increasing frailty is often delineated as a characteristic of aging and old age. As a phenomenon it is intrinsic to human experience. The frailty of older persons is, therefore, not a feature setting them apart from younger persons. Rather, an "unalterable given in human existence is the possibility of injury and destruction, the quality of frailty."[4] The meaning that is given to the experience of human frailty is reflective of the more general values the culture gives to the understanding of the human condition. The dominant rationalist perspective today works with the understanding that what cannot be understood rationally is not essential but contingent, accidental. So when frailty disrupts an otherwise rational and seemingly infinite life, the finitude of the flesh cannot be ignored. When experience is

[3] G. Berg, and S. Gadow, "Toward More Human Meanings of Aging: Ideals and Images from Philosophy and Art" in *Aging and the Elderly. Humanistic Perspectives in Gerontology*, edited by S. F. Spicker, K. M. Woodward, and D. D. Van Tassel, (Atlantic Heights, N.J.: Humanities Press, 1978), 86

[4] S.A. Gadow, "Frailty and Strength: The Dialectic of Aging" In *What Does It Mean to Grow Old? Reflections from the Humanities*, edited by T. R. Cole and S. Gadow, (Durham, N.C.: Duke University Press, 1986), 238

dominated by the body's dysfunction and disfigurement, dignity seems salvageable only through a sharp distinction between body and self to prevent the person being defined as totally disabled. The self rejects the body to escape being contaminated by its deterioration. The dichotomy entailed here is not simply that between self and body, but points to the contradiction within the self - the subject regards himself or herself as an object.[5]

> Moreover, the rationalist view of the body not only precludes a self-body unity in aging by forcing the self to renounce the body, it also undermines the relation between the self and its world. As a physical and social object, the body - in good health or ill - belongs to the world as well as to the self.[6]

An existentialist understanding of human frailty, especially that experienced in old age, sees decay and weakness as not so much the manifestation of the body's decline but as the lack of vitality in the self to embrace one's life, including the life of the body with its unceasing tides of strength and frailty. The existential opportunity in aging, greater than at any other time in the life journey, is to cultivate a conscious integrity of self and body, to cherish and not renounce the body, to care for it as one would a beloved with whom one has laughed and danced and from whom one soon will be parted. Frailty is not simply the antithesis of energy. It is itself an intense experience and brings with it new life.[7]

The ambiguity of one's subjective experience of aging, the changing sense of time that comes with slowing down, the changes in the aging person's physical body and the very profound sense of personal frailty are but some of the ways in which all who share the common human experience of aging encounter the reality of longevity. As is obvious already the human mind seeks to grasp the experience, to understand it in some way.

2.1.1.2 The Meaning of the Experience

The topography of old age may be charted by the following existential and moral questions: Why do we grow old? Does aging have an intrinsic purpose? Is old age the culmination or the dreary denouement of life's drama? Is there anything important to

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5 This will be developed in more detail in chapter 3 when Taylor's notion of the *punctual* self explores the same experience.

6 Gadow, "Frailty and Strength...," in *What Does It Mean to Grow Old?*, 240.

7 Gadow, "Frailty and Strength...," in *What Does It Mean to Grow Old?*, 243. Berg and Gadow point to the works of the aged Michelangelo, Rembrandt, Beethoven, Yeats, Picasso and Tolstoy to substantiate this point. Cf. Berg and Gadow, "Toward More Human Meanings of Aging...," in *Aging and the Elderly*, 88-92; B. Friedan, *The Fountain of Age*, (New York: Simon & Schuster, 1993), 123-124

be done after children are raised and careers completed? Are there perduring gifts reserved for age? Has death always cast its shadow over old age? What are the rights and responsibilities of older people? What are the virtues of old age? Has there ever really been a *good* old age? The culture within which answers might be developed is not much interested in *why* we grow old, or how we *ought* to grow old, or what it *means* to grow old. Modern biomedical and social science is primarily interested in *how* we age, in order to understand and control the aging *process*.[8]

In seeking meaning the quest is directed to the purpose and intelligibility that people find, or attempt to find, in their lives. The quest for meaning is the consequence of the ineluctable urge to make sense of one's life - to seek justifications and to construct a narrative, a story of one's life, that makes sense, that makes of it a whole. The search for meaning has an inner and an outer aspect. Our quest for an inner sense of purpose (the sense that there is after all a point to this life) and integration (the sense of wholeness, that all this seeming chaos fits together) is paralleled by the need for shared public understandings (the ways of life a particular culture offers its members). These available social forms can vary according to one's age, sex, or other characteristics.[9]

In his attempt to determine a public meaning for aging Daniel Callahan looks first for a shared interpretation of the physical realities of old age that will help the elderly themselves. He looks next for an interpretation of the social reality of old age that will provide a moral foundation for public policy.[10] He observes two obstacles to public conversation that might arrive at a public meaning for old age. First, a reluctance in a pluralistic society to talk about questions of value and meaning, particularly when they go beyond the public space into private lives. Second, the apparent lack of a single secular civic tradition that gives public meaning to old age makes it difficult to know which language and tradition to draw upon in approaching the topic. Two realities must be held in tension if progress is to be made. The significance of the elderly *as a group* must be given due weight if intergenerational obligations are to be valued. Closely connected with this are the ways for building the common good by assuring appropriate social, economic, and moral roles for the elderly in society. The patent danger here is to allow the group generalisations,

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8 T. R. Cole, "Oedipus and the Meaning of Aging: Personal Reflections and Historical Perspectives", *Generations* 14:4 (1990): 30

9 T.H. Murray, "Meaning, Aging, and Public Policy" in *Too Old for Health Care? Controversies in Medicine, Law, Economics and Ethics*, edited by R. H. Binstock and S. G. Post, (Baltimore: The Johns Hopkins University Press, 1991), 168-169

10 D. Callahan, "Can Old Age Be Given a Public Meaning?", *Second Opinion* 15 (1990): 18

however valid, to overwhelm the no less valid generalisation that the elderly, though old, retain the same individuality as all other age groups. Age does not vanquish individuality.[11] To the extent that the contemporary world does not offer elderly persons social roles full of meaning, they are at risk of lapsing into anomie, feelings of worthlessness and resentment, and self-preoccupation.[12]

At its core aging is fundamentally a *mystery* rather than a *problem*. Failure to appreciate that aging shares the dimension of mystery with life as a whole takes human inquiries into meaning along unsatisfactory paths. This is well illustrated by a frequently quoted story about T.S. Eliot. At the close of a lecture on a serious moral problem, an undergraduate rose to ask urgently, "Mr. Eliot, what are we going to do about the problem you have discussed?" Eliot replied, in effect, "You have asked the wrong question, 'What are we going to do about it?' Another presses the different question, 'How does one behave towards it?' The first kind of problem demands relatively technical, pragmatic and programmatic responses; the second kind poses a deeper range of challenges, hardy perennials, which no particular policy, strategy or behaviour will dissolve."[13] Harry Moody makes the point well when he writes that a plurality of meanings will not be eliminated by appealing to a natural life course nor by Rawlsian arguments that separate the right from the good. On the contrary, public policy can and must take seriously a variety of different ideas about a good old age:

> Certain ideas about meaning and value - for example, quality of life, successful aging, or intergenerational solidarity - are problematic because they involve difficult philosophical questions about the purpose of human life and especially the last stage of life. Both technocratic discourse and an exclusively procedural theory of justice try to evade these hard choices, but they will find that questions about the meaning of old age come back to haunt us in the end: the 'return of the

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[11] Callahan, "Can Old Age...," 18, 22. The problems of a liberal democracy are well illustrated by Thomas Murray when he asserts that "[a]lthough the tradition of liberal individualism inspires commendable respect for the liberty and dignity of individuals, it also carries with it two major problems for a moral community. First, its emphasis on individual liberty makes discussions about what constitutes a good life problematic...Second, liberal individualism tends to presume that self-interest is the fundamental human motivation, that the only moral obligations with others are much like the relations between nations: governed by contract (usually implied rather than explicit) and motivated by mutual self-interest." Murray, "Meaning...," in *Too Old for Health Care?*, 174

[12] Murray, "Meaning...," in *Too Old for Health Care?*, 175

[13] W.F. May, "The Virtues and Vices of the Elderly" in *What Does It Mean to Grow Old? Reflections from the Humanities*, edited by T. R. Cole and S. Gadow, (Durham, N.C.: Duke University Press, 1986), 49

> repressed', as Freud might have put it. Perhaps it is better to wrestle with these demons right now.[14]

The central role of *meaning* in the human project arises from the ambiguous role it plays. In fact it allows the individual to connect the world of public understanding, in this case about aging, with the inner struggle for personal wholeness as one ages. In contemporary life, unfortunately, the dominant public understanding about aging dissolves the essential and creative tension that should exist between corporate and personal meanings.[15] Scientific meanings of aging are separated from and elevated above experiential or existential understandings. This has vital implications for any dealings with aging persons. Not to prize their experience and the process of understanding and giving meaning to this part of their life journey is radically undermining of their uniqueness, individuality and dignity.

2.1.2 Explaining the Experience of Growing Old

2.1.2.1 A History of the Attempt

The search for a meaning to old age and growing old reaches back to the beginnings of written records. Sophocles, in *Oedipus Rex* and *Oedipus at Colonus*, offers to contemporary readers profound insights into aging, death and generational succession.[16] Before the action of *Oedipus Rex* begins Oedipus saves the city of Thebes from the Sphinx who is strangling its inhabitants for being unable to answer her riddle: "What goes on four legs in the morning, two legs at noon, and three legs in the afternoon?" "Man" replies Oedipus. Man crawls as an infant, walks upright in his prime and hobbles with a cane in old age. Man is the animal whose three ages of life demand different forms of movement. Oedipus's solution to the riddle cannot ultimately save him or save Thebes. Unrelated to his own origins or destiny, Oedipus's answer is incomplete, uninformed by self-knowledge. Oedipus remains a riddle to himself.

Years after the death of Laius when the action of *Oedipus Rex* begins, the city of Thebes is suffering from a plague sent by the gods for the unsolved murder of the old King. With the same confidence with which he solved the riddle Oedipus proclaims he will find the murderer and banish him from Thebes. Thus slowly unravels the

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14 H.R. Moody, "The Meaning of Old Age: Scenarios for the Future" in *A World Growing Old. The Coming Health Care Challenges*, edited by D. Callahan, R. H. J. ter Meulen, and E. Topinkova, (Washington, D.C.: Georgetown University Press, 1995), 18

15 Cf. T.R. Cole, *The Journey of Life. A Cultural History of Aging in America*, (Cambridge: Cambridge University Press, 1992), xviii

16 What follows is dependent on Cole, "Oedipus...," 31-33

mystery of Oedipus's own origins, the story of patricide and incest, leading to blindness, horror and exile. With *Oedipus at Colonus* Sophocles portrays the self-blinding and exile of Oedipus as the beginning of a long journey to insight, inner knowledge and wisdom. Led by his daughter, Antigone, Oedipus wanders for twenty years arriving at the sacred grove of the Furies of Colonus. At this point he sees, as an old man, that he has lived all his life in accord with the oracle's prophecy and that trying to evade its fate only intensified its power over him. *Oedipus at Colonus* is the only Greek tragedy to centre around an aged hero. It was, in fact, written by the eighty-nine year old Sophocles who envisaged the elderly Oedipus as a tragic hero. It portrays aging as a moral and spiritual journey. Its surprises, terrors, mysteries, and triumphs can only be successfully crossed with humility and self-knowledge, love and compassion, acceptance of mortality and a sense of the sacred.

The world of ancient Greece and Rome viewed the human life cycle as part of the immutable order of nature.[17] The human journey through life was imbedded in the order of the cosmos and the experience of senescence was seen as part of the structure of reality. This essentialist or ontological understanding of human aging linked aging to the underlying patterns of the universe. Aristotle divided human life into three parts: growth, *stasis* and decline. The man at the height of his powers is the ideal ruler. He is neither young nor old. This explanation of life on the basis of the rise and fall of physical power was complemented by a sevenfold division of the life cycle originating with the the astronomer Ptolemy. It was based on an understanding of the movement of the planets and became a popular framework in the late medieval period.

Hippocrates, Aristotle, Cicero and Galen became the principal authorities of the Graeco-Roman world for theories about the nature and causes of human aging. Aristotle defined old age as that period of life when the body's innate heat diminishes.

> Heat was the essence of life according to Hippocratic medicine, the source being the heart, conceived as a sort of furnace. From the heart, heat was sent to the whole body for the purpose of maintaining a healthful balance of humors. Each individual possessed a finite amount of heat that steadily diminished in the natural course of life. Although it could be fortified or replenished temporarily, vital heat could never wholly be restored. In time, the fire of life would eventually be quenched.[18]

Galen developed this understanding. He proposed that blood and semen, the sources of generating the human individual, required a drying agent. Vital heat dried these

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[17] Cf. G. Minois, *History of Old Age. From Antiquity to the Renaissance*, (Chicago: University of Chicago Press, 1989), 43-112

[18] Cole, *The Journey of Life*, 8

agents thus producing the human embryo. The drying process continued throughout the individual's life.[19] The infant is moist, the old person quite dried out. For him old age meant dessication. It is interesting to note that for Aristotle old age was a time when normal failings were magnified, when physical decline and the loss of inward heat depressed the spirit. His understanding of virtue led him to believe that individuals can show nobility even in the misfortunes of old age.[20] Old age entails a diminishment of the passions. The ancient philosophers saw this as one of the blessings that accompanied the disintegration of aging. "The Stoic value of unimpassioned judgment gave old age a prized status."[21]

Throughout the Hebrew scriptures both positive and negative views of aging are to be found.[22] For the ancient Hebrews it was the elderly Abraham who became an instrument of God's salvation in Israel. The demands of the Covenant required respect and care of parents.[23] The commandment to honour father and mother entailed a more inclusive ideal than simple support.[24] It enjoined an attitude of reverence and affection akin to worship, and the promise of long life for those who observe it made it a solemn covenantal obligation. The practice of the early Christian communities assumed the Jewish tradition and developed it. In their care of widows the early Christian community expressed its understanding of *agape* or charity. Women sixty years of age and older without family to support them could give themselves to a life of prayer and good works in return for maintenance by the Church community.[25] Widowhood was thus a significant and flexible social invention in the Christian community as it cared for older vulnerable women.[26]

Two themes prevail in Western Europe from the early medieval period to the Renaissance. The first portrayed human life as a *journey*, the second divided life into

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19 P. Brown, *The Body and Society. Men, Women and Sexual Renunciation in Early Christianity*, (London: Faber and Faber, 1991), 10-11

20 D. Christiansen, "Aging and the Aged: III. Ethical Implications in Aging" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, vol.1, (New York: Simon and Schuster Macmillan, 1995), 59. Cicero adopted a similar understanding in *De senectute.*

21 Christiansen, "Aging and the Aged...," in *Encyclopedia of Bioethics*, 59

22 A detailed understanding of the Judeo-Christian scriptures on old age will be given in 7.1 below. Here it is necessary only to mention the salient points of the tradition. For a general survey see Minois, *History of Old Age*, 25-42

23 Ex. 21:15, 17; Lev.20:9; Dt.27:16; cf. Matt.15:3-7

24 Ex.20:12

25 1 Tim.5:3-16

26 "By the second century, it included both genuine widows who carried out works of mercy and unmarried women living a secluded life of prayer; and by the twelfth century, women who had been released from their marriage vows, e.g. to found convents, could be admitted to formal widowhood..." Christiansen, "Aging and the Aged...," in *Encyclopedia of Bioethics*, 59

ages or *stages*. Each offered a way of conceiving the fragmented, sometimes chaotic, everchanging lifetime as a unified whole. This imagined whole, within which various parts of life can be located, guaranteed a coherent (if not always happy) place for aging and old age.[27]

The ages of life framework inherited from the ancient world came to be absorbed, in time, into a Christian view of the *pilgrimage of life*. This latter perspective continued up until the sixteenth century. The early Church teachers had conceived life on earth as a pilgrimage. The metaphor gained in power as the experience of pilgrimages to Jerusalem, Rome and other holy places became more common during the eleventh to thirteenth centuries. The mendicant preachers emphasised the transitory and changing character of human life as well as the temptations that awaited the unwary on their journey from stage to stage in life. Adapting old motifs like the tree of life, the wheel of life, the wheel of Fortune, artists increasingly depicted the ages of life to enhance meditation on the mystery of the human journey. At the centre they placed Christ. This Christ-centered vision redeemed humanity from its natural cycle and subordinated seasonal time to sacred time. Earthly time becomes a mere shadow of eternity. Most people had little idea of their chronological age. Their age of life was determined largely by rites of passage - the rituals surrounding birth, marriage, and death. Since retirement had no place in traditional European folk culture, old age as a stage of life was not set apart by specific transition rituals or customs.[28] Plagues, famines, epidemics, and infectious diseases prevented most people from growing old, giving it much thought, or asssociating death exclusively with old age.[29]

The monastic community shaped the day around the divine office. As village churches and town halls installed mechanical clocks to ring the hours there grew a modern notion of time. It came to be seen as a precious commodity, to be used before it fled. Luther's emphasis on justification by faith raised the life cycle to a new significance. Once one's life became justified, time acquired a new meaning. The old anxieties about time and death received a new focus. "In the pre-Reformation period, the deathbed had been a battlefield determining a soul's eternal fate. By the seventeenth century, the whole of an individual's life became important."[30] In their

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27 Cole, "Oedipus...," 31

28 There is evidence of contracts of retirement in some medieval marriages. It would appear that elderly parents were in a particularly weak position. Cf. F. and J. Gies, *Marriage and the Family in the Middle Ages*, (New York: Harper & Row, 1989)

29 Cf. Cole, *The Journey of Life*..., 11; T. Cole, and M. Holstein, "Aging and the Aged. V. Old Age" in *Encyclopedia of Bioethics*. revised ed., edited by W. T. Reich, (New York: Simon & Schuster Macmillan, 1995), 99

30 Cole, *The Journey of Life*, 23

place came a concern about bodily health and control of the body. During and after the Reformation, the traditionally circular representations of life's stages were recast iconographically into a rising and falling staircase, a visual map of the life course, complete with virtues and vices for each stage of life. Protestant writers and artists urged people to seek a long, orderly and stable life. They wove together qualifications for salvation with requirements for longevity. In doing this they sketched the map which the secular, institutionalised life course of the modern era would be built.[31]

The ideal of a long, orderly and secure lifetime did not become a reality until this century. During the nineteenth century scientific thinking directed its concerns to *how* we grow old: a move from ontology to physiology. The preoccupations of science, medicine and technology had now replaced the philosophical and religious understandings that sought to explain *why* we grow old. Two notions that will be continually re-visited in the course of this thesis must now be raised. The first is the notion of the *life course* or the normative life-cycle, the second is the concept of the *natural* life span.

2.1.2.2 The Normative Life Cycle

Martin Kohli, in his study of what he calls the *moral economy of the life course*, proposed that:

> chronologization of the life course has been greatly advanced by the modern age-stratified systems of public rights and duties. Those with the most far-reaching effects are the school system and the old-age pension system; they have created the age boundaries that today constitute the basic tripartition of the life course. Within the boundaries set by the school system, the emergence of age-homogenized classes . . . has contributed to further chronological ordering.[32]

Old age as a distinct stage in the life journey is a relatively recent phenomenon. It has been argued that old age in the modern sense only came into existence when the majority of workers in society were salaried. Complementing these social changes was the transformation of the individual life span from a pattern of relative randomness to one of predictability. Since death is now concentrated in the upper age brackets demographers speak of the process of *rectangularisation* of the survival

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[31] Cole and Holstein, "Aging and the Aged...," in *Encyclopedia of Bioethics*, 99

[32] M. Kohli, "The World We Forgot: A Historical Review of the Life Course" in *Later Life. The Social Psychology of Aging*, edited by V. W. Marshall, (Beverly Hills: Sage, 1986), 280

curve.[33] While the mean duration of life has risen substantially the maximum duration of the human life has remained essentially the same. The development of the life cycle has gained in importance in contemporary societies because of the emergence of the age-stratified public systems of rights and duties which presupposes knowing a person's chronological age. This was given legal force when age thresholds were institutionalised in the legal systems of different nations. Three consequences follow on this public organisation. First, emphasis increasingly came to be given to long range planning:

> The life plan - even though typically open-ended and often vague - has become 'a primary source of identity' and 'a basic organizing principle' for orientation in social reality. Life planning requires a specific mode of temporality: Life is conceived by the individual as a 'designed project', in other words, its meanings 'derive from future plans rather than from the explication of past events' [34]

Second, biographical stages in the life journey are linked to the life-cycle plan accepted within a given society. Third, the individualisation of life is viewed in developmental terms. An outcome of this process has been a form of social control. As Kohli sees it:

> [a] key part of this new form of social control is the institutionalization of the life course as a sequential program taking a long-range perspective on life. Thus, we could argue that the new life regime is the necessary correlate of individualization. Rules of membership have been replaced by rules of temporal order.[35]

This sociological proposal goes some way to explaining how the organisation of modern industrial societies has created a framework which has contributed to increasing anxiety about the meaning of old age. Harry Moody is a trenchant critic of this state of affairs. He argues that for much 20th century philosophical reflection the meaning of life has disappeared and resurfaced in a privatist form, viz., the meaning of *my* life.[36] The modernised life-cycle is divided into three boxes: childhood, employment, retirement. The result has been a covert ideology of life span

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33 The demographic dimensions of *rectangularisation* have been explored in chapter 1. Fries's theoretical explanation of this phenomenon in terms of a *compression of morbidity* will be examined in 2.2 below.

34 Kohli, "The World We Forgot...," in *Later Life*, 284. The author goes on to refer to a related change proposed by Berger and others, viz., that "the concept of 'honor' has become obsolete and has been replaced by the concept of 'dignity'. Honor links the person to the social aggregate (e.g. family or estate) and thus refers to a membership classification, while dignity refers to claims based on individuality." (*ibid.*, 284)

35 Kohli, "The World We Forgot...," in *Later Life*, 288

36 H. R. Moody, "The Meaning of Life and the Meaning of Old Age" in *What Does It Mean to Grow Old?*, edited by T. R. Cole and S. A. Gadow, (Durham, N.C.: Duke University Press, 1986), 12

development. This lacks any rational foundation for shared public values in a way that explicates the notion of development. He argues that to understand the meaning of life attention must be paid to three levels of understanding: the individual, the collective and the cosmic. The present task is to justify the purposes that give meaning to life. Otherwise the psychology of the life span development falls apart conceptually.[37]

The modernisation of the life-cycle is characterised by a two-fold development: (1) the separation of life into separate stages and age-groups, and (2) the displacement of the meaning of old age.[38] Breaking the life-cycle into three boxes erases the image of the unity of human life. A dual displacement of meaning takes place as a consequence of this. First, there is a displacement of leisure, contemplation and meaning from the rest of adulthood into old age. Second, death, finitude and judgment are moved from the afterlife into the present life. Unlike traditional societies where myth and ritual shape the rites of passage over the life course, the shape of the contemporary life course is more and more subject to the professional expertise of specialists in this or that segment of the life course.

Childhood and retirement are today absorbed into the planning and control systems of society. The problem at the heart of contemporary management of society is that three demands conflict: a cultural drive for maximum autonomy on the one hand opposes an economic drive for efficiency and control on the other; a lack of interest in welfare stands against the values of autonomy and efficiency. Moody argues that it is the task of the ideology of the life span development to mask these contradictions at every point. The newest form of these covert ideological interpretations is the claim that we are entering an *age irrelevant* society.[39] Where the rigid segmenting of the life course is breaking down a blurring of the boundaries is occuring. In fact what is happening is that "the early and late stages of the life course are absorbed into the

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37 This has a bearing on criticism of Erikson's psychological explanation of aging.

38 Moody, "The Meaning of Life...," in *What Does It Mean to Grow Old?*, 34

39 "Over a decade ago Bernice Neugarten noted the trend toward an 'age-irrelevant' society. Her point was that there is less and less consensus about the values or appropriate goals for different stages of life, including the final stage. The trend toward an age-irrelevant society has the important consequence for resource allocation in public policy: "it erodes any consensus about the legitimacy of age-based entitlements, such as pensions and health coverage." H. R. Moody, "The Meaning of Old Age: Scenarios for the Future" in *A World Growing Old. The Coming Health Care Challenges*, edited by D. Callahan, R. H. J. ter Meulen, and E. Topinkova, (Washington, D.C.: Georgetown University Press, 1995), 19. See B. L Neugarten and D. A. Neugarten. "Age in the Aging Society", *Daedalus* 115:1 (1986): 31-49. The authors conclude by proposing that perhaps "the most constructive ways of adapting to an aging society will emerge by focusing, not on age at all, but on more relevant dimensions of human needs, human competencies, and human diversity."(*ibid.*, 47)

endless present of perpetual young adulthood, now the dominant ideological image of the ideal worker-consumer."[40]

Elsewhere Moody examines the meaning of old age from the viewpoint of the postmodern life course:

> Today old age as a period of life is becoming less determinate, less role-governed, and other life stages are moving in that direction as well. What is happpening is a restructuring of life-span socialization to match the coming of an 'information society', a 'postindustrial society', or, more recently, the 'postmodern culture'.[41]

The modernised life course, with its rigid boundaries, was a product of bureaucratic industrialism, which concentrated productivity in the middle years in the name of efficiency. The modernised life course was anchored in the primacy of the economy and the subordination of self to the rationalised requirements of the social order: stay in school, work hard, build up seniority, prepare for retirement. A linear life course reflected that logic. The postmodern life course, by contrast, with its fluid movement and multiplicity of life-styles, is based not on productivity but on consumerism. The postmodern life course is essentially an extension of the norm of middle age in two directions: downward (the 'disappearance of childhood') and upward (the 'third age'). Postmodern culture promises an escape from constraints and stereotypes of age-based norms of all kinds. "Whether that promise is an illusion or a realistic hope for emancipatory change remains to be seen."[42]

Old people engage in autobiographical reflection, reminiscence and life-review.[43] When the question of meaning is transposed to the level of autobiography, what results is a set of conditions for inquiring into the intelligibility of life review. These conditions focus on causality, teleology and happiness, viz., that my life be understandable, that it be purposeful, and that it be happy. In short, the concept of the meaning of *my* life is a multivalent concept, a set of resemblances weaving together interrelated but distinct ideas:

> What I suggest is that, philosophically speaking, there are a variety of 'languages', 'metaphors', or 'world hypotheses' that constitute a plurality of conceptual paradigms for looking at the meaning of life through autobiographical consciousness. Within each of these conceptual paradigms, the life review can be judged according to values

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40 Moody, "The Meaning of Life...," in *What Does It Mean to Grow Old?*, 38

41 H. R. Moody, "Overview: What Is Critical Gerontology and Why Is It Important?" in *Voices and Visions of Aging*, edited by T. R. Cole, (New York: Springer, 1993), xix

42 Moody, "Overview…,"in *Voices and Visions of Aging*, xx

43 Moody, "The Meaning of Life...," in *What Does It Mean to Grow Old?*, 24

> of truth, authenticity, integrity, and so on. But each of the conceptual paradigms remains incommensurable with the others.[44]

Life review, autobiographical consciousness and the developmental psychology of life stages are modern ways of structuring human time, the time between birth and death. The literature exploring these significant dimensions of the normative life cycle has been drawn primarily from American and European sources. It is interesting to note here that very little Australian academic analysis is to be found on the humanistic perspectives about aging. While there is a large body of literature on the practical management of the aged care industry, there is a dearth of Australian material on the issues Kohli and Moody have considered.

2.1.2.3 The Natural Life Span

In the exploration of the work of Daniel Callahan and Norman Daniels to be undertaken later in chapter 4 it will be noted that both thinkers assume a *natural* life course as the necessary background for their ethical analysis.[45] This assumption has been much criticised in light of developments in recent biological explanations of aging and because of the spread of cultural norms that erode any consensus about a natural old age. In his discussion of four scenarios of an aging society Harry Moody offers an excellent insight into the strengths and weaknesses of the natural life span perspective. He explores the assumptions and implications of the natural life span in terms of four scenarios which focus on prolongation of morbidity, compression of morbidity, the imperative to extend life and the biomedicalisation of old age.[46]

The first scenario views aging as involving a prolonging of morbidity. The very technologies that enabled aged persons to survive longer than if they lived according to *nature* is itself an *unnatural* state of affairs. The influence of Stoicism in human history with its imperative that the human good is only possible when humans live *according to nature* must be balanced by an equally important Stoic principle that human reason guides the moral agent to the fulfillment that is to be found according to nature in any given instance.[47] Because of this the determination of where right

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44 Moody, "The Meaning of Life...," in *What Does It Mean to Grow Old?*, 27. Psychological autobiography reduces life review to a causal-psychological process; in spiritual autobiography life review is seen as the path to salvation or deliverance; the literary or artistic form of autobiography arises when life review is viewed as a manifestation of artistic creativity. (*ibid.*, 27-28)

45 Cf. J.P. Parry, "Life Cycle", W.M. Runyan, "Life Histories", D.A. Kramer and P.B. Baltes, "Life Span Development" in *The Social Science Encyclopedia*, edited by A. Kuper and J. Kuper, (London: Routledge & Kegan Paul, 1985), 462-465

46 Moody, "The Meaning of Old Age...," in *A World Growing Old*, 15-17

47 Cf. A. Battaglia, "Natural Life-Span and Natural Law Ethics" in *Facing Limits. Ethics and Health CAre for the Elderly*, edited by G. R. Winslow and J. W. Walters, (Boulder, Co.:

action lies is not found by looking to an abstract natural life course but, instead, is to be found in a *quality-of-life* standard. The second scenario portrays the theory that contemporary aging brings with it a compression of morbidity. This approach takes for granted that there is a natural boundary to the duration of human life. The human body is an organic system that is bound to wear out in a fixed period of time. This is the natural state of things. The compression of morbidity thesis is made to bear too great a load. It does not follow that a natural life course framework justifies resource allocation throughout the life course as Daniels has argued. Rather, in this approach old age itself is transformed into a prolongation of middle age:

> According to the compression-of-morbidity framework, the only thing deemed ineluctably natural is an upper limit on the life span itself. But the meaning of the last stage of life, and therefore the ethical basis for allocating resources among life stages, remains wholly unnatural and subject to human choice and technological intervention.[48]

The third scenario emphasises the imperative to extend the human life span.[49] Prolongevity thinking extends the idea of progress by challenging the natural limits of human existence. Instead of normal aging the focus shifts to the notion of aging as a disease to be conquered and cured. A refusal to adopt technologies for extending the human life span must not be based on passive acceptance of limits but only on the conscious decision that humans will not take this path of technological development.

The fourth and final scenario entails a rejection of the biomedicalisation of old age in favour of what Jürgen Habermas calls the *life-world.* This scenario seeks to capture some of the virtues of the traditional idea of stages of life. More broadly this evokes an ideal of vital involvement and concern by the elderly for the welfare of future generations. This approach invests old age with purpose and meaning not only within the human life course but also within a cosmic scheme of things.[50]

An influential psychological explanation of the meaning of aging that assumes the natural life span framework is to be found in the work of Erik Erikson. Erikson's psychology mixes a loose form of phenomenological description with an evolutionary-adaptive explanation of human life, both at the level of the individual

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Westview Press, 1993). 69-86. This natural law approach has been the dominant argumentation in Roman Catholic moral thinking (cf. chapter 6)

48 Moody, "The Meaning of Old Age...," in *A World Growing Old*, 16

49 For the influence of this approach in human history see G. J. Gruman, "Longevity" in *Dictionary of the History of Ideas. Studies of Selected Pivotal Ideas*, edited by P. P. Wiener, Vol.3, (New York: Charles Scribner's Sons, 1973), 89-93

50 Moody's favours this fourth scenario. As seen in the previous section his acceptance of a post-Christian and post-modern world leads him to see the related deconstruction of nature as requiring conscious choice and mutual dialogue based on personal and community narratives.

and the wider human species.[51] The categories of time and temporality pervade all of Erikson's stages, e.g., generativity and stagnation, integration and despair.[52] Generativity for Erikson entails a concern for establishing and guiding the next generation. When generativity overcomes stagnation he believes there emerges the virtue of *care*, a widening concern for what has been generated by love, necessity, or accident. Integrity, the virtue of old age, is an acceptance of the individual's one and only life cycle with no basic regret that it should have been otherwise.[53] It also involves a detached yet active concern with life in spite of declining vitality and approaching death.[54] Integrity presupposes the prior attitude of generativity; it makes it possible for a person to live with what he has been given and what he has brought into this world that is likely to survive him."[55]

Erikson's contribution to the psychology of adulthood and aging constitutes a new paradigm within psychoanalysis for an understanding of the human being. Although aging may necessarily involve increasing degrees of disengagement Erikson maintains that achieving a sense of continuity with the cycle of generations through care and appropriate forms of usefulness is a pervasive need of people throughout the aging years.

The philosophical and psychological explanations of the natural life span account indicate some of the complexities latent in the quest to comprehend the meaning of old age in contemporary first world societies.

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[51] Browning, "Preface...," in *Toward a Theology of Aging*, 157

[52] Cf. D. S. Browning, *Generative Man: Psychiatric Perspectives,* (Philadelphia: Westminster, 1973), 197-200. In developing his psychological explanations Erikson fuses certain scientific models taken from biology, ecology and evolutionary theory to his phenomenology of the life-course. The most important of these models is the *concept of epigenesis* borrowed from the biologist C.H. Stockard. Erikson understands epigenesis to be the idea that everything that grows has a ground plan and out of this ground plan the parts arise, each part having its time of special ascendancy, until all parts have arisen to form a functioning whole. This concept applies primarily to ego development. For Erikson this achieved a considerable shift in the basic logic of psychoanalysis. The concept of epigenesis implies that environmental influences have a role in activating preexisting biological potentials. This is true for all the stages of development, including the crucial adult stage of generativity versus stagnation.

[53] C. Power, A. R. Power and J. Snarey, "Integrity and Aging: Ethical, Religious, and Psychosocial Perspectives" in *Self, Ego, and Identity: Integrative Approaches*, edited by D. K. Lapsley and F. C. Power, (New York: Springer, 1988), 130-50

[54] E. H. Erikson, "Reflections on Dr. Borg's Life Cycle" in *Aging, Death, and the Completion of Being*, edited by D. D. Van Tassel, (Philadelphia: University of Pennsylvania Press, 1979), 29-67

[55] Browning, "Preface...," in *Toward a Theology of Aging*, 158-159; cf. S. Weiland, "Erik Erikson: Ages, Stages, and Stories", *Generations* 17:2 (1993): 17-22.

2.1.2.4 Scientific Explanations of Aging

From a scientific viewpoint aging is defined as the accumulation of chronological events that render an organism more susceptible to the stresses of life and thereby increase the probability of death.[56] Rates of aging are governed by two major factors: (1) the specific genetic background of the species and (2) its interaction with the environment. The mean life span of a species is related to the processes of aging in that the accumulation of deleterious events reduces the ability of the organism to survive environmental insults, including the lessening of individual defence systems and increasing the susceptibility to many diseases. Aging is, therefore, not a disease to be cured but rather a complex series of biological alterations to be understood.

The factors causing aging are multiple. They are both internal to the organism and environmental, causing molecular and cellular damage which contributes to the aging of the organism. Many theories have been proposed to account for aging.[57] A group of explanations, the so-called *stochastic* theories, point to random damage resulting from myriad environmental insults. *Programmed* theories, on the other hand, suggest that life span is under active, genetic control, for example by processes that limit cell division. It is more likely that aging is both stochastic and programmed and that it involves both environmental and genetic factors. No one explanation is comprehensive or totally satisfactory.[58]

2.1.2.5 Sociological Explanations of Aging

The sociological literature on old age has also been quite varied and on the whole incompete. It has mostly tended to treat aging in terms of social welfare policies. This approach has focused on the consequences of social arrangements and the *ad hoc* responses made to discovered needs.[59] Since the 1950s American and British

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56 G. R. Martin, and G. T. Baker. "Aging and the Aged. I. Theories of Aging and Life Extension" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, (New York: Simon & Schuster Macmillan, 1995), 85

57 E.g. somatic mutation theory, error catastrophe theory, free-radical theory, cross-linkage theory, redundant message theory and glycation theory. Cf. Martin and Baker. "Aging and the Aged...," in *Encyclopedia of Bioethics*, 86; see also M. A. Horan and A. Brouwer, eds., *Gerontology. Approaches to Biomedical and Clinical Research*, (London: Edward Arnold, 1990), 2-6; I. Davies, "Biology of Aging - Theories of Aging" in *Textbook of Geriatric Medicine and Gerontology*, 3rd. ed., edited by J. C. Brocklehurst, (Edinburgh: Churchill Livingstone, 1985), 62-81; A.. Hipkiss and A. Bittles. "Basic Biological Aspects of Ageing" in *Human Ageing and Later Life. Multidisciplinary Perspectives*, edited by A. M. Warnes, (London: Edward Arnold, 1989), 3-14; S. J. Olshansky, B. A. Carnes and C. K. Cassel, "The Aging of the Human Species", *Scientific American* 268:4 (1993): 2-8.

58 I. Davies, "Biology…," in *Textbook of Geriatric Medicine and Gerontology*, 77

59 Fennell et al., indicate that social gerontologists "have been happier to describe the activities and lifestyles of older people, rather than consider causal linkages between ageing and the social,

commentators saw old age as a functional problem. Old age was "essentially viewed as a problem of adult socialization: how could older people be re-integrated within a social order which was undergoing rapid change?"[60] Changes such as compulsory retirement, the rise of the nuclear family, the impact of industrialisation and urbanisation, together with increased rates of social and geographical mobility were perceived to be significant.

Three approaches in social gerontology merit consideration here, namely the functionalist, contextualist and constructionist explanations. The first gives particular emphasis to the impact of social roles in determining individual behaviour (the *functionalist* perspective). The loss of a meaningful role in life through retirement was considered to demoralise the retiree and effect a loss of self-esteem. A more psychological approach, again focusing on the experience of removal from the workforce, emphasised the withdrawal or *disengagement* that occurs in the initial period. When the aging process is complete the equilibrium which existed in middle life between the individual and his society has given way to a new equilibrium characterized by a greater distance and an altered type of relationship.

From the 1960s onwards the second approach involved attempts to contextualise the aging process (the *contextualist/historical* approach). Attention was first given to the life and work histories of elderly people. This approach emphasised the continuities present in aging. "These continuities are seen to arise through having a particular biography which gives meaning to old age . . . ,through membership of a particular class, gender or ethnic group and through being a member of a cohort (a group of people born within a specified time period) which may influence certain characteristics of ageing."[61]

A decade later the political and economic dimensions of the life histories of aging people focused on an understanding of the social construction of old age. This signalled the beginnings of the third or constructionist approach. At a time when demographic concerns, awareness of limited resources and economic constraint were uppermost in public life, the aged were seen as an increasing burden. Proponents of the social construction of old age argued that the status and resources of the elderly, and even the experience of old age itself, are conditioned by one's location in the social structure and the local to global economic and social factors that shape that

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political and economic structure." G. Fennell, G., C. Phillipson and H. Evers, *The Sociology of Old Age*, (Milton Keynes: Open University Press, 1993), 41

[60] Fennell, Phillipson and Evers, *The Sociology of Old Age*, 43

[61] Fennell, Phillipson and Evers, *The Sociology of Old Age*, 49-50

location. Old age is thus seen as a social rather than a biologically constructed status. A consequence of this viewpoint is that health and welfare services are seen to reinforce the dependency created through the wider social and economic system. Older people may find themselves being treated and processed as commodities. Welfare services were criticised for stigmatising older people, compounding their problems through the imposition of age-segregated policies.[62]

2.1.2.6 *The Ethical Meaning of Aging*

The ethical dimensions and meaning of old age may be best seen in the light of two negative realities in the lives of the elderly today. There is a danger that elderly people will be marginalised in the moral community by one of two processes. The first is the use of language. As people age they can become increasingly dependent on others for their everyday needs. Referring to them as *clients* or *patients* reinforces an attitude that they are passive recipients of all that is offered.[63] The imbalance of power that sometimes occurs where philanthropy is the driving force in the care that is being offered reinforces rather than redresses the imbalance in the relationship. The result frequently is to deny the elderly person moral agency and moral responsibility for particular areas in their lives.

The second sign of marginalisation of the elderly in the moral community is the failure to engage in justified criticism of them. Failure to criticise them may subtly remove them from the human race. It pretends, in effect, that they are moral nonentities. It treats them in a condescending way as though they were objects. An important development occurs when the community attends to the aged in a serious way, treating them as moral beings, approving or reproving their behaviour.[64] The moral status of the elderly is valued when the community reflects on the virtues of old age in the context of the adversities that come with aging.[65]

2.1.3 Implications for Just Health Care

The six ways of explaining the reality of aging that have been explored in this section indicate how central and pervasive the phenomenon of aging has been for the human psyche. This has been expressed throughout history in a multiplicity of ways. Some

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[62] Cf. Fennell, Phillipson and Evers, *The Sociology of Old Age*, 54

[63] The term *client* originates with the role of the lawyer who as advocate *speaks for* the person in arguing the case. The term *patient* emphasises what is undergone by the person who is ill or suffering. Cf. May, "The Virtues...," in *What Does It Mean to Grow Old?*, 45

[64] May, "The Virtues...," in *What Does It Mean to Grow Old?*, 43

[65] May, "The Virtues...," in *What Does It Mean to Grow Old?*, 50

of the more significant have been explored in the preceding pages. The historical, life cycle, natural life span, scientific, sociological and ethical dimensions of aging will be revisited throughout the rest of this thesis. Each of these perspectives contributes to a fuller understanding of aging that bears on the dominant concern of this thesis, namely justice and health care.

2.2 WELL-BEING: WHAT DOES IT MEAN TO BE HEALTHY OR ILL?

Chapter 2 has focused to this point on a humanistic approach to the problematic issues that arise with the aging both of the individual and of society. Narrowly focused or reductionist explanations of senescence, it has been argued, do not offer adequate answers to the fundamental quest for the meaning of human longevity. The previous section has sketched the disparate directions human inquiry has journeyed in this search. In light of this it is possible to conclude that humanistic approaches offer perspectives on aging that are more comprehensive and qualitatively richer than that to be found in Australian aged care throughout the last century.

It has already been noted that aged care in Australia could not be isolated from a number of other important dimensions such as demography, housing and finance. There is a similar imperative to consider other issues related to human aging if a more adequate proposal is to be articulated in regard to just health care for aged Australians. The two issues of importance here are necessitated by the thrust of this study. First is the understanding of health and illness that is assumed when analysing human aging. Our conceptualisation of what it means to be healthy or ill must necessarily be quite different for the individual who is eighty years old as against the situation of a child or young adult. In general the potential for a healthy life style will differ for people at different stages in life. Multiple and chronic illnesses are more likely in one's later years. There is greater likelihood of long or short-term disability being present. Because of this a reappraisal of contemporary notions of health and illness are needed for a society where healthy, active and youthful bodies are taken as the norm. The reality of aging, in fact, is causing modern first world societies to reconsider the prevailing understandings of health and illness. A changing view of the health/illness landscape suggests a second problematic. What does it mean to care for an elderly person with a particular set of health limitations? As the years go by there is likelihood that an aging person will experience frailty, illness or disability making him or her increasingly dependent on others. Health care systems are dominated at present by the imperative to cure. Technology offers a continually

increasing set of life-extending and life-enhancing therapies. The preoccupation of critical care medicine with cure must confront the issues implicit in care for aging persons for whom cure is no longer an option. Care of such persons, often over long periods of time, challenges contemporary society to re-think its notion of medicine but most especially its understanding of care. It is to these two problematic human issues that this study now turns. As with the issue of aging the two topics will be discussed in three stages: the experience, the explanations, the implications.

2.2.1 Experiencing Health and Illness

How do people think of health? The healthy person usually takes his or her health for granted. To be healthy is to be freed from some of the limitations and problems that promote self-reflection. The healthy individual need not pause before getting up out of the chair, walking to the door and opening it, planning activities for the coming weekend or doing the odd jobs around the house after work. The state of health, bodily and psychic, that allows for such engagements usually remains in the background. This is not always the case. For instance one may enjoy the return to health after a bad dose of influenza but generally these contrasting experiences which bring health to consciousness sooner or later fall away. Health returns to its status as the forgotten dimension of a healthy existence. In fact this experiential absence remains an implicit presence in daily living.[66] Being able to carry out activities without difficulty assumes the character of a taken-for-granted horizon of sufficient health. It is this which enables activity. This obliviousness to one's healthy state is not an existential evasion of something significant. Rather, such a state of affairs frees the person to engage in the outer world. [67]

The word *health* has the same root as the word *whole*. To be healthy is to be in a state of relatively unproblematic wholeness.[68] The body is operating harmoniously and is thus able to meet the demands of its world and carry out the self's intentions. The healthy person is able to integrate into his or her social surroundings. In this integration of self and body, self and world, self and others, the healthy person lives like a fish in water inhabiting an all-embracing and invisible milieu.

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[66] D. Leder, "Health and Disease. V. The Experience of Health and Illness" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 2, (New York: Simon & Schuster Macmillan, 1995), 1107

[67] The phenomenological approach used by Leder builds on the work of Heidegger and Merleau-Ponty. For a detailed exposition of this see D. Leder, *The Absent Body*, (Chicago: University of Chicago Press, 1990)

[68] The long used English expression "hale and hearty" epitomises this wholeness, particularly as it applies to the elderly who enjoy reasonable health.

Illness, however, teaches humans the precariousness of this world. Persons, like fish, can also be plucked out of the cocoon of healthy existence and cast into alien environment, flopping and gasping for breath. When illness comes a lack of health becomes evident and many of the features of health, until now taken for granted, are perceived in a new way through reflection and remembering:

> Thus, there appears to be an *experiential* priority of illness, which is that of a *negative* experience, while there is a clear *logical* priority of health, as the necessary condition for that experience to be and to be recognized as such. Yet, the fact that health is a necessary condition for the experience of illness indicates that health is *more original*, even if experienced in an often unexpressed and not clearly conscious way, and mostly only *after* some form of illness has appeared.[69]

It takes but little reflection to recognise that health is not simply symmetrical with illness. The concept of illness has a more delimited meaning than that of health which is richer and wider and hence more indeterminate. There is something more to health than just the reverse of disease. It can only be alluded to, it would appear, through a negation. Part of the difficulty may be that our experience and understanding of health presupposes the intuition of a certain biological normativeness. Here the good condition of body and self is considered as a unified whole in harmony with the environment. Furthermore, this good condition indicates an opening to fulness:

> This means health is a *premise* for further achievements, but, as such, it is also a *token*, a first achievement (or rather a gift) against the threats that finitude inevitably entails and thus a *promise* of further achievements. We might describe health, then, as 'the opening of the bodily self to plenitude', where the modalities of this opening must be *analogically* recognized in *the different dimensions of experience*.[70]

In order to capture the profound dislocations caused by illness it is useful to distinguish between *illness* and *disease*. Since the eighteenth century disease classifications have moved progressively from a basis in the patient's reported symptoms to one grounded on either the pathological lesions and processes exposed after death or by medical technologies in the living. The term illness has been used to refer to the experience of the sick person. If health is a kind of wholeness, a multi-dimensional integration, illness involves a set of experienced dis-integrations. This is best observed in relation to the body. When a person is healthy the body is transparent - assumed and unproblematic. When one becomes ill the body becomes

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[69] R. Mordacci, "Health as an Analogical Concept", *The Journal of Medicine and Philosophy* 20:5 (1995): 478

[70] Mordacci, "Health...," *The Journal of Medicine and Philosophy*, 492. Modacci's analogical understanding of health mirrors the medieval scholastic use of analogy as found in Thomas Aquinas.

opaque, something alien. It is what causes pain, limiting movement, humiliating the person with its unpleasant look or odour. The ill person frequently does not understand or control what is happening within his or her body in the experience of illness. Such an experience may often be a challenge to the usual sense of the autonomous self.

Four things of note follow on this. First, one's relationship with one's own body often must be mediated through others, as when the doctor diagnoses or the surgeon intervenes in the inner workings of the body. Second, the bodily dis-integration typical of illness suffuses the experience of space and time. Confined to bed the sick person finds his or her way to the future blocked. Third, bodily dis-integration brings with it a dis-unity with others. No longer part of the mainstream the sick person may feel distanced, especially when in pain and suffering, from those who are healthy and go about their daily lives. Loneliness can contribute greatly to the suffering of the ill. Fourth, deeper questions arise in the experience of illness forcing the sick person to confront his or her place in the cosmos. In the light of this multi-dimensional understanding illness effects an existential transformation.[71]

Two of the most powerful dis-integrating forces in illness are the experience of pain and suffering. Pain asserts itself not only via a sensory intensification but through its characteristic temporality (its episodic structure) for example as an ongoing stream of sensation. This is also the case with chronic pain which grabs the person's attention with undiminished intensity. Chronic pain retains this episodic character - as if the pain were born anew although nothing whatsoever has changed.[72] Pain has a unique qualitative feel that sets it apart from other sensory experiences. It places on the sufferer an *affective call* - one's attention is summoned by the gnawing, distasteful quality of pain in a way not the case with other more neutral stimuli.

The full phenomenological import of pain is only revealed when set within a broader context. Pain effects an *intentional disruption* and a *spatio-temporal constriction*. Correlatively the painful body emerges as an *alien presence* that exerts a *telic demand*.[73] First, the healthy person lives from his body to the world, i.e. it is transparent.[74] No longer simply a *from* structure, the painful body becomes that *to* which the person attends. As the body surfaces thematically its transitive use is

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[71] Leder, "Health and Disease...," in *Encyclopedia of Bioethics*, 1108-1109

[72] Leder, *The Absent Body*, 72-73

[73] Leder, *The Absent Body*, 73-79

[74] For the healthy person the body is like a glove or an instrument that appears to have a seamless connection with the body in the performance of tasks. As such it is transparent.

disrupted. In striking the sufferer alone pain tends to induce self-reflection and isolation. Second, pain affects the person's experience of space and time. Intense pain is experienced spatially as either the contraction of the universe down to the immediate vicinity of the body or as the body swelling to fill the entire universe.[75] The close relationship betwen the experience of time and of pain can be seen in the common origins of the words *chronic* and *chronology*, *endurance* and *duration*. Pain restructures and dictates the sufferer's perception of time.[76] The ability to interpret pain and make sense of it within a life story is linked to the unstressed time that is available for reflection. Respites from pain, however brief, provide the necessary interpretive distance that allows for the transformation of pain. Interpretation of pain that is not dominated by anxiety and dread can restore a sense of autonomy to the sufferer. Reflecting on pain as a discernible sequence of physical sensation and psychic response makes possible its incorporation into a larger sequence, the individual's life story. Time can be used, then, to transform pain and restore the autonomy of the sufferer. Knowledge of pain gives the sufferer some mastery over it.[77] Because of its effects pain exerts a phenomenologically centripetal force gathering space and time inward to the centre. Pain ceaselessly reminds the individual of the here-and-now body. The body is no longer a transparent, unproblematic part of the self but an active presence whose call is to be resisted.

Third, pain configures the body as something alien. Patients often describe their pain as an *it* separate from the *I*. The painful body is often experienced as something foreign to the self. Thus an understanding of the body as object does not arise solely as a result of modern scientific medicine. To fully understand the alien presence of the painful body it is necessary to look at the projects it brings into play. Pain exerts a *telic demand* on us.[78] While calling the person in pain to the *now*, its distasteful quality also establishes a future goal, namely to be free of pain. On a more complex level pain's telic demand includes what Leder terms a *hermeneutical* and *pragmatic*

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[75] E. Scarry, *The Body in Pain: The Making and Unmaking of the World*, (New York: Oxford University Press, 1985), 35

[76] L. H. Landon, "Suffering Over Time: Six Varieties of Pain", *Soundings* 72:1 (1989): 75. The author examines six varieties of pain, each distinguished by the way it transforms time: (1) unendurable pain, (2) dependable pain, (3) unreliable pain, (4) guilty pain, (5) catastrophic pain, (6) expected pain. (*ibid.*, 75-81)

[77] Landon, "Suffering Over Time...," *Soundings*, 81-82

[78] This is the language proposed by David Bakan in *Disease, Pain and Sacrifice. Toward a Psychology of Suffering*, (Chicago: University of Chicago Press, 1968), 70-73. Bakan understands disease as "decentralization of this higher telos of the organism, and its loss of dominance over the lower tele." (*ibid.*, 32)

moment. Suffering gives rise to a search for interpretation and understanding.[79] When in pain the body becomes the object of an ongoing interpretive quest (the hermeneutic task).

At this point it is appropriate to distinguish *pain* from *suffering*. Suffering is closely related to pain because pain is a common cause of suffering. They are, however, distinct forms of distress.[80] *Pain* may be understood as acute or chronic physical, mental or emotional distress associated with some disorder (injury or disease). It may also arise from other unpleasant stimuli characterised by discomfort which the mind perceives as an injury or threat of injury to one portion of the self. *Suffering*, on the other hand, is of a different order. It is an anguish which one experiences on one level as a threat to personal composure, integrity and the fulfillment of intentions but at a deeper level as a frustration of the concrete meaning that the individual finds in personal existence. Anguish over the injury or threat of injury to the self and thus the meaning of the self stands at the core of suffering.[81]

2.2.2 Explaining the Experience of Health and Illness

2.2.2.1 Health

Two approaches to the understanding of health merit consideration here: a wholistic one proposed by the World Health Organisation (WHO) and a view that attends to the subjectively perceived state of equilibrium in the person.[82] First, health has been defined by the WHO as "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." To understand the significance of this definition consideration must be given to its social and political context and purposes. At the time of its ratification it was intended to justify international involvement in the internal affairs of countries. Whether medicine can offer explanations and therapies to achieve complete multifunctional well-being was and is

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79 For an outline of the interpretative tasks involve see W. T. Reich, "Speaking of Suffering: A Moral Account of Compassion", *Soundings* 72:1 (1989): 83-108

80 E. J. Cassell, "Pain and Suffering" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 4, (New York: Simon & Schuster Macmillan, 1995), 1899

81 Cf. Reich, "Speaking of Suffering...," *Soundings*, 83-108; see also Cassell, "Pain and Suffering" in *Encyclopedia of Bioethics*, 1899. The theological perspectives on suffering will be explored in 7.1 below.

82 Cf. H.L. Blum, *Planning for Health: Development and Application of Social Change*, (New York: Behavioral Publishers, 1974) and *Expanding Health Care Horizons: From General Systems Concept of Health Care to a National Policy*, (Oakland, Ca.: Third Party Publications, 1983). Blum's nine definitions of health are succinctly presented in B. M. Ashley and K. D. O'Rourke, *HealthCare Ethics: A Theological Analysis*, 3rd.ed., (St.Louis: Catholic Health Association of the United States, 1989), 21-22

vigorously debated. Furthermore, the definition also incorporates social and spiritual dimensions into the notion of health. This emphasis offered a starting point for an exploration of the moral and political responsibilities of the international community for health care especially in developing countries.[83]

The WHO definition of health has been criticised for incorporating too much. An individual may be healthy without being in a state of complete physical, mental and social well-being. Some degree of disease and infirmity is perfectly compatible with mental and social well-being. It is doubtful that there is ever more than a transient state of complete physical, mental and social well-being in human lives. Daniel Callahan proposed a narrower definition of health as *a state of physical well-being*:

> That state need not be *complete*, but it must be at least adequate, i.e., without significant impairment of function. It also need not encompass *mental* well-being; one can be healthy yet anxious, well yet depressed. And it surely ought not to encompass *social well-being*, except insofar as that well-being will be impaired by the presence of large-scale, serious physical infirmities.[84]

Second, health may be also understood as an equilibrium within the person. Illness forces a change in existential states. It is only partly defined medically as a concrete organic or psychosocial aberration. It is the perception of the change in existential states that forms the central experience of illness - the perception of impairment and the need to be made whole again - to be cured, healed, or cared for. The perception is personal and unique, since each person has a different meaning for health and illness. We feel healthy when we are in a state of equilibrium between our already experienced shortcomings and our aspirations and thus have adjusted our goals to the gap between them. Health is a state of accommodation, defined in different terms by each person. Illness rudely upsets that equilibrium.[85]

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[83] D. von Engelhardt, "Health and Disease. I. History of the Concepts" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 2, (New York: Simon & Schuster Macmillan, 1995), 1090-1091

[84] D. Callahan, "The WHO Definition of Health" in *Biomedical Ethics*, edited by T. A. Mappes and J. S. Zembaty, (New York: McGraw-Hill, 1981), 210. LeRoy Walters adopts a similar position: "health is functional normality or, in the words of Leon R. Kass, 'the well-working of the [physical] organism as a whole.'" L. Walters, "In Search of Health" in *On Moral Medicine. Theological Perspectives in Medical Ethics*, edited by S. E. Lammers and A. Verhey, (Grand Rapids, Mich.: William B. Eerdmans Publishing Company, 1987), 158

[85] E. D. Pellegrino, "Being Ill and Being Healed. Some Reflections on the Grounding of Medical Morality" in *The Humanity of the Ill*, edited by V. Kestenbaum, (Knoxville: The University of Tennessee Press, 1982), 157-158; cf. E., Pellegrino and D. C. Thomasma, *The Christian Virtues in Medical Practice*, (Washington, D.C.: Georgetown University Press, 1996), 58-59

2.2.2.2 *Illness, Disease and Sickness*

Disease refers to the medical conception of pathological abnormality, to organic malfunctioning, to objectively measurable disorders.[86] *Illness*, on the other hand, refers to subjective feelings of not being well, that is to the subjective or personal side of disease. *Sickness* transcends both of these concepts by focusing on social consequences.[87] The term refers to a social identity. In this it is distinguishable from *disease* which is a biological concept and from *illness* which is a sociopsychological concept. As a social identity, sickness is a label bestowed by others and publicly accepted by the individual. While sickness is usually assumed to reflect disease or illness, it may occur independently of either and must not be confused with them. Societies frequently distinguish between understandings of sickness. Depending on personal or cultural factors individuals may define themselves as *sick* in response to a variety of feelings of illness, e.g. pain, weakness, nausea or in response to incapacity to perform accustomed tasks or in response to observed bodily changes such as unusual lumps. This variability is particularly to be noted in the differences of understanding regarding mental illness. Political dissent, religious expression or homosexuality have been variously defined as mental sickness. [88]

Two metaphors may be used here to convey the prevailing approaches to contemporary understandings of non-health. The first is that of the *machine*. Scientific medicine has viewed the human body as a machine, its malfunctioning as *disease*. The alternative might be imaged as a *tapestry*. Biosocial views focus on the person in the context of a community. *Illness* and *sickness* characterise non-health in this model.

Medicine and the natural sciences have concentrated in recent history on curing disease. Matters such as the maintenance of good health were neglected and the contribution of the arts, literature, and theology to the understanding of illness was ignored. As a result of this the patient became increasingly an object to study and

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86 The very term *disease* (dis-ease) expresses well the experienced loss of comfort and possibility that often accompanies physiological disruption. Etymologically, *ease* comes from the French word *aise*, originally meaning *elbow room* or *opportunity*. This experience of world-as-opportunity is precisely what dis-ease calls into question. Disease, even more than pain, is typified by complex patterns of dysfunction. In disease one is actively "dis-abled". Leder, *The Absent Body*, 79-81

87 Engelhardt, "Health and Disease...," in *Encyclopedia of Bioethics*, 1085

88 Sociologically speaking sickness, like crime and sin, is a form of deviant behaviour. Deviance consists in failure to perform one's role expectations, to fully participate in the social system. P. I. Ahmed, A. Kolker and G. V. Coelho, "Toward a New Definition of Health: An Overview" in *Toward a New Defintion of Health. Psychosocial Dimensions*, edited by P. I. Ahmed and G. V. Coelho, (New York: Plenum Press, 1979), 10-11

investigate. The individual's subjectivity or personality was disregarded and the patient's history was reduced to the history of the disease. This notion of disease concentrates primarily on weakness, loss and damage. The question focuses on whether there are mono-causal or multifactorial explanations of the disease phenomenon.[89] Historically scientific controversies portrayed disease entities as primarily metaphysical, clinical, pathological, etiological, or genetic. More recent conceptualisations of disease have become non-ontological and more pragmatic in character. A choice can be made as to whether a disease such as tuberculosis may be viewed as an infectious, genetic or environmental disease.[90]

The prevailing scientific view of disease not only emphasises the objectivity of the disease but also adopts a reductionist methodology. Christopher Boorse proposed the paradigm case for this reductionist conceptualisation.[91] According to him all living beings have evolved as the result of a long evolutionary process, in which genotype, phenotype and environment have interacted to produce organs with particular functions that contribute to the life of the organism. Health in this view is the functioning of any living thing in conformity with its natural design. Normal functioning thus determines health and is statistically definable through empirical observation and measurement.[92] Health is "the readiness of each internal part to perform all its normal functions on typical occasions with at least typical efficiency."[93] In this Boorse attempts to provide a value-free account of disease.[94]

Epistemological and sociological concerns fuelled a reaction to the certainties of scientific medicine. Critics argued that the truth and knowledge which accounted for the scientific view of disease involve certain structures of power and exclusion that

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89 Engelhardt, "Health and Disease...," in *Encyclopedia of Bioethics*, 1089-1091

90 H. T. Engelhardt and K. M. Wildes, "Health and Disease. IV. Philosophical Perspectives" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 2, (New York: Simon & Schuster Macmillan, 1995), 1102

91 C. Boorse, "On the Distinction Between Disease and Illness", *Philosophy and Public Affairs* 5 (1975): 49-68; C. Boorse, "Wright on Function", *Philosophical Review* 85 (1976): 70-87; C. Boorse, "What a Theory of Mental Health Should Be", *Philosophy and Science* 44 (1977): 542-73.

92 *Normality* in the species is based on the notion of natural function. Thus *natural* and *normal* are identical in the sense that what is found to be normal in biology, i.e. the statistical standard in organisms of the same species, age and sex, is therefore to be considered *natural, in the nature of the species, in accordance with its design.* Cf. Mordacci, "Health...," *The Journal of Medicine and Philosophy*, 479

93 Boorse, "What a Theory...," *Philosophy and Science*, 562

94 Implicit in the objectivist view proposed by Boorse is a positivistic, analytic framework that advances the separability of fact and value, as well as the separability of science, ethics and metaphysics. Cf. G. Khushf, "Expanding the Horizon of Reflection on Health and Disease", *The Journal of Medicine and Philosophy* 20:5 (1995): 461

are untenable and should be questioned.[95] Critical analyses have emphasised the way social and cultural frameworks condition concepts of health and disease. As a result of these attacks the presuppositions were absorbed into the wider problematic of pluralism that has preoccupied recent social and political philosophy. Post-modern deconstruction has also given impetus to a libertarian concept of medicine and medical practice that threatens the integrity of medicine itself. H.T. Engelhardt epitomises this way of thinking. He argues that what one counts as health and disease necessarily involves value-laden considerations as to what one judges human well-being to be. For this author rational free agency is proper to humans. Health is thus the state where one possesses the physiological and psychological prerequisites of rational free agency. States which restrict rational free agency are identified as disease.[96]

Attempts to bridge the gap between the two approaches mirrored in the metaphors of machine and tapestry have been undertaken in recent times. The challenge is to conceptualise health, disease and illness in a way that addresses the epistemological, axiological and metaphysical issues associated with them. At the same time attention must also be paid to the culturally conditioned character of human knowledge and the pluralism of perspectives that results. A further imperative is to give a sufficiently rich meaning to the concepts so that practical concerns can be concretely addressed and sufficient dialogue between diverse conceptualisations can be advanced.[97]

Definitions of well-being and illness must also take account of the specific roles the individual is expected to play in his or her cultural milieu, especially in the family and at work. The sick role as well as the various well roles are, according to this view, dynamic social identities that must be continuously negotiated between the individual, his or her immediate social network and the health professional. The achievement of consensus is by no means guaranteed. This model of health (a *biosocial* model) incorporates as objective data the values and expectations of the individual and of those around him or her. These behavioural and attitudinal data supplement observed biological data in developing an integrated model of health and disease. Biomedical notions of disease focus on diagnosis, etiology, and (usually) chemical corrective action. Socio-psychological and cultural factors may be used to

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95 The influence of Michel Foucault is to be noted here. Cf. M. Foucault, *The Birth of the Clinic: An Archeology of Medical Perception,* (trans.) A.M.S. Smith, (New York: Vintage Books, 1975)

96 This provides the basis for the individualistic libertarianism that has shaped all of Engelhardt's writings. H. T. Engelhardt, "Human Well-Being and Medicine: Some Basic Value-Judgments in the Biomedical Sciences" in *Biomedical Ethics*, edited by T. A. Mappes and J. S. Zembaty, (New York: McGraw-Hill, 1981), 213-22

97 Khushf, "Expanding...," *The Journal of Medicine and Philosophy*, 465

devise an integrated program to treat the illness and to restore health. The integrated biosocial model, then, does not sacrifice the demonstrated advantages of the biomedical model, rather, it seeks to supplement them.[98] A biosocial approach permits one to conclude that the illness perspective provides a more comprehensive view. It incorporates individuals and their families as they make sense of, respond to, cope with, and adapt to symptoms and disabilities.[99]

A sociological perspective of the role of the sick person has been portrayed in terms of two freedoms and two sets of obligations: freedom from daily duties and from responsibility for the sick condition, and the obligations to want to become well again and and to seek medical help. Descriptive and normative aspects permeate this sociological view of the sick person's role. Disease is not only described in its social causes and consequences, it also assumes demands and expectations.[100] Since Parsons introduced his theories on the sick role in 1951 many have described various aspects of the illness experience. In light of this approach a comprehensive illness model has been proposed. It (1) incorporates the entire duration of the illness experience, beginning with the onset of symptoms, (2) allows for the expression of the dynamic nature of illness, (3) attends to the patient's perspective, (4) identifies the similarities that arise from illness, rather than the underlying disease, (5) incorporates the entire context of the illness into the model, and (6) is developed inductively without implying or imposing a previously developed model.[101]

This brief study of the various theories of health and its opposite (in terms of disease, illness or sickness) makes three things clear: (1) partial explanations of the phenomena are inadequate; (2) all explanations are grounded in basic philosophical understandings of epistemology, metaphysics and social theory, and (3) more comprehensive approaches to health and illness offer a better understanding of the phenomena.

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98 Ahmed, Kolker and Coelho. "Toward...," in *Toward a New Defintion of Health*, 13-14

99 J. M. Morse, "Understanding the Illness Experience" in *The Illness Experience. Dimensions of Suffering*, edited by J. M. Morse and J. L. Johnson, (Newbury Park, Ca.: Sage Publications, 1991), 2

100 Engelhardt, "Health and Disease...," in *Encyclopedia of Bioethics*, 1090; For Talcott Parsons' sociological approach to the sick role see T. Parsons, "Health and Disease. III. A Sociological and Action Perspective" in *Encyclopedia of Bioethics*, edited by W. T. Reich, Vol. 2, (New York: Free Press, 1978), 590-599.

101 Morse, "Understanding...," in *The Illness Experience*, 2-3. A more comprehensive view of illness called the *Illness-Constellation Model* builds on these six elements. The theory focuses on the person and considers illness behaviour as the ability of the ill person to cope with or to respond to the disease process. Cf. J. M. Morse and J. L. Johnson, "Toward a Theory of Illness: The Illness-Constellation Model" in *The Illness Experience. Dimensions of Suffering*, edited by J. M. Morse and J. L. Johnson, (Newbury Park, Ca.: Sage Publications, 1991), 315-42.

2.2.3 Implications for the Aged

In light of the tensions between between scientific and biosocial explanations of health and illness there is an increasing readiness to accept a psycho/social/somatic/ environmental framework for health. Viewed from the perspective of older people, these inter-connected aspects stand out in bold relief because (1) medical problems (disease and disability) increase with advancing age, (2) these problems play more important roles as determinants of social functioning, (3) the elderly are more dependent and vulnerable in their physical and social environments, and (4) unlike children whose physical and social dependencies are transitional and are met primarily through the family, a proportionately larger share of the supportive and long-term health and social services needed by older people must be provided by the community.[102]

A more comprehensive perspective of health and illness will undoubtedly reverse what has been called the the *medicalisation* of health and aging.[103] The inclusive nature of some understandings of health, such as that of the WHO, has contributed to the assumption that medical care is equivalent to health. The danger arising from this is to measure resources allocated to medical care and conclude that, to the degree it is increased or diminished, the health of the aged population has likewise improved or deteriorated. Medicalising life can create a perception that health is a medical concern, that the problems of health are medical problems, that the objectives of health are medical objectives and that to care for health is to provide medical care.[104] This narrowing of the agenda is seductive since it provides readily quantifiable criteria for assessing the health of the population or sectors within it. Medicalisation of aging generates a further concern in relation to the research undertaken on elderly subjects. It has been argued that research should be directed to diminishing the physical limitations associated with biological aging. If this were done the elderly would be able to live vigorous, productive and non-dependent lives.[105] Research involving the elderly must be assessed not only in terms of the reasonable advances

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[102] A. J. Havighurst, "Coping with Health Problems in Aging" in *Toward a New Defintion of Health. Psychosocial Dimensions*, edited by P. I. Ahmed and G. V. Coelho, (New York: Plenum Press, 1979), 235

[103] I. Illich, *Limits to Medicine. Medical Nemesis: The Expropriation of Health*, (London: Penguin Books, 1990) has subjected the medicalisation of health to a thorough going critique.

[104] J. Ladd, "The Concepts of Health and Disease and Their Ethical Implications" in *Value Conflicts in Health Care Delivery*, edited by B. Gruzalski and C. Nelson, (Cambridge, Mass.: Ballinger Publishing Company, 1982), 23

[105] L. Hayflick, "Aging and the Aged. I. Theories of Aging and Anti-Aging Techniques" in *Encyclopedia of Bioethics*, edited by W. T. Reich, Vol. 1, (New York: Free Press, 1978) [check ref.]

in scientific knowledge that might accrue, but also in terms of criteria governing research. In relation to this it has been observed that "the poorer in knowledge, motivation, and freedom of decision . . . the more sparingly and indeed reluctantly should the reservoir be used."[106]

The medicalisation of aging and health raises a further issue concerning the goals of contemporary medicine. This matter will be subjected to further analysis in chapter 4. It suffices here merely to note that medicine has been characterised as "a relation of mutual consent to effect individualized well-being by working in, with and through the body."[107] In the doctor-patient relationship the complex requirements of the individual patient are primary. The medium of the doctor-patient encounter is the human body of both doctor and patient. As Alistair Campbell observes:

> reference to the bodies of both doctor and patient identifies the unique feature of medical acts as bodily relationships. Medicine deals with embodiments of distress (including those which are found in mental and emotional forms, yet still embodied in an individual life), and it deals with it by means of the body - by vision, hearing, touch. Medicine is not *only* physical, but it is *in essence* physical. When the body is lost sight of, medicine becomes some other activity.[108]

This element is vital for understanding the goals and methods of medicine when at the service of the elderly. Not only must there be a clear understanding of what is to be hoped for in the doctor-aged person meeting but the way in which the meeting is *physical* is extremely significant for the healing process entered into.

The English word *health* means *wholeness*; *to heal* means to *make whole*. In Greek two words are used for the notion of healing: *hygieia* means *a well way of living* and *euexia* means *good habit of body*. It is worth noting that both the English and Greek words for health are totally unrelated to all the words used in these languages for disease, illness and sickness. The Greek words for healing, unlike those used in English, are unrelated to all the verbs for healing. Health for the ancient Greeks was a state or condition unrelated to, and prior to, both illness and healers. In English the emphasis on wholeness in the notion of healing is comparatively static and structural,

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106 Jonas quoted in E. W. D. Young, "Aging and the Aged. IV. Health Care and Research in the Aged" in *Encyclopedia of Bioethics*, edited by W.T.Reich, Vol.1, (New York: Free Press, 1978), 68; see also G. A. Sachs, "Aging and the Aged. IV. Health-Care and Research Issues" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 1, (New York: Simon & Schuster Macmillan, 1995), 94-97

107 E. D.Pellegrino and D. C. Thomasma, *A Philosophical Basis of Medical Practice. Toward a Philosophy and Ethic of the Healing Professions*, (New York: Oxford University Press, 1981), 80

108 A. V. Campbell, *Moderated Love. A Theology of Professional Care*, (London: SPCK, 1984), 28-29

implying a whole distinct from all else and complete in itself. It connotes self-sufficiency and independence. The Greek notion of healing, on the other hand, stresses the functioning of the whole, not only its working but its working well.[109] Two consequences flow from these different emphases. First, healing is understood in terms of integrity, in the light of an objective paradigm. Scientific medicine best exemplifies this approach. The second perspective, in stressing the functioning of the whole, gives priority to what is appropriate to the person in youth, active adulthood or old age. For this reason health and illness must be judged primarily in terms of appropriateness, capacity to function, age and one's life projects.

An elderly person who has a disease, is ill or sick looks to be healed. Contemporary scientific medicine has operated with both a dualistic and mechanistic understanding of the human body. The doctor's task, as scientist and technician, is to fix or replace a broken part. Many sensitive clinicians, however, have sought to be healers of illness not simply treaters of disease. "To *heal* is to begin reweaving into wholeness the tapestry of life shredded by illness."[110] Even when disease is not curable, the medical practitioner can seek to relieve pain and preserve physical function. Ultimately, healing is not just the reconstruction of an earlier life but the building of something new. Healing occurs when a new equilibrium is established between the person's hopes and failures and where these are incorporated into the individual's personal project. As such, healing must be built on an authentic understanding of the illness experience in the existence of each person.[111]

Western culture has conferred upon doctors the role of the care of the sick. While the role of doctors as the curers of disease is clear, their role as healers remains obscure. For this reason, then, it is important to explore understandings of healing for they have relevance to the direction of this thesis. The power to heal may be viewed from three points of view. The first derives from the training the doctor has received in the craft of healing. The second flows from the healer's personal qualities and character. The third derives from the social status the healer has within a particular society. While competence, virtue and status provide foundations for the profession of healing it must be associated with certain dispositions on the part of the healer. In showing compassion, the healer empowers the patient in a way that the act of curing a disease cannot. Curing disease eliminates a threat to bodily function and integrity. Alleviating suffering, on the other hand, restores persons who are suffering, connects

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109 J. P. Browder and R. Vance "Healing" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 2. (New York: Simon & Schuster Macmillan, 1995), 1032

110 Leder, "Health and Disease...," in *Encyclopedia of Bioethics*, 1111

111 Browder and Vance, "Healing" in *Encyclopedia of Bioethics*, 1032

them with the rest of humanity and gives them the ability to make sense of their own lives.[112] The healing relationship thus entails a sharing of power. This enables the patient to move towards wholeness (healing). This empowering process takes place when it is realised that curing does not necessarily ensure healing and that healing is possible even if there cannot be a cure.

A vital component in the process of healing is the role of the community to which the person belongs. Healing is a communal action. It reaches out to those isolated by illness reconnecting them to the human family. Furthermore, it is sustainable only within a community that practices compassion as a virtue. The future of the healing professions depends as much on this nurture as on technical competence and the wise use of material resources.[113] The implications of compassionate healing are well grasped by Drew Leder when he reflects on the fact that

> [f]or many illness serves as the oyster grit from which a pearl is formed: a deeper compassion for others, perhaps, or a greater intimacy with loved ones; an attentiveness to the joys of ordinary living, or a reordering of lifestyle and priorities; the development of virtues such as courage or patience; an acceptance, perhaps, of the vulnerability and dependence of all human life and the need for powers beyond the self. The suggestion that illness can be a grace is not a licence to grow callous to the suffering it involves . . . the patient and the practitioner alike can remain open to the healing gifts that illness itself may bring.[114]

2.3 CARE: WHAT DOES IT MEAN TO CARE?

The third *meaning* question that calls for attention in this chapter follows on the above discussion of the meaning of aging, health and illness. What does *to care* for someone mean, particularly when that person is elderly, frail, ill, disabled or demented? This has particular urgency in societies challenged by increased longevity? Prior to this century brief periods of illness in old age frequently resulted in death. The elderly also constituted a minority in the total population. Today, however, long periods of morbidity and disability exist in an aging population that is a rapidly increasing number and proportion of the total population.

Twentieth century health care has emphasised the importance of curing the ill and the diseased.[115] Phenomenal success has been achieved in this area. However, living

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[112] Browder and Vance, "Healing" in *Encyclopedia of Bioethics*, 1036

[113] Browder and Vance, "Healing" in *Encyclopedia of Bioethics*, 1037-1038

[114] Leder, "Health and Disease...," in *Encyclopedia of Bioethics*, 1111

[115] "The word *cure* is now used by many health professionals in a radical sense: to refer to the eradication of the cause of an illness or disease - to the radical interruption, and reversal, of the

longer has forced Promethean humanity to confront the inevitability of decline and death - for which there is no cure! It is particularly care of the aged and the dying that has caused *care* to assume increasing importance in contemporary health care. Care of and for the aged in contemporary first-world societies raises questions as to the scope of care. How long must we offer care? What sort of care should be offered? Who must, who might and who ought to offer this care? These questions have a particular sharpness in light of the demands of chronic illness, the types and extent of disability in old age and the requirements of various forms of long-term care. In light of these pressing questions it is necessary in view of the direction of this thesis to explore the issue of care, to elucidate the implications for care in a society growing old.

This section follows the same tri-partite division as the previous two sections of chapter 2. Following a reflection on the experience of care a number of explanations of the notion of care will be explored. Very much like Russian dolls particular notions of care are seen to fit within larger notions. Modern scientific medicine fits the notion of care within a wider concept of cure.[116] In this thesis I argue that the concept of *medical cure* nests within the wider notion of *medical care* which in turn nests within a comprehensive understanding of *care*. This reverses the order presumed in contemporary medical practice. In what follows the historical evolution of the notion of *care* provides a background for an analysis of *medical care* which then leads to a consideration of an ethic of care.

2.3.1 The Experience of Care

An extreme case best exemplifies the experiential dimension of care. The case of Donald Cowart is used here because, in his situation, the normal cues and expectations are lacking as to how care might be offered to him. His difficult predicament calls for a dimension of care that exceeds mere delivery of caring service according to current professional standards. The *extra* dimension of care and caring implied in Cowart's situation will be taken up later in a theological context, in chapter 7.3, when *charity-as-care* is portrayed as emphasising motivation and performance.

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natural history of a disorder...The possibility of *cure*, in this sense, turns on the availability of scientific medicine." E. D. Pellegrino, "The Caring Ethic: The Relation of Physician to Patient" in *Caring, Curing, Coping. Nurse, Physician, Patient Relationships*, edited by A. H. Bishop and J. R. Scudder, (Alabama: University of Alabama Press, 1985), 9

116 The notion may be expressed colloquially: "we aim to cure; when we cannot cure, we care".

Donald Cowart was severely burned and for ten years endured the life of a patient burned, blinded, without use of his hands and regularly subjected to excruciating interventions.[117] This tragic situation is an arresting one. Anyone comprehending the situation could not but feel for him as a fellow human being. The painfulness of his situation can be easily imagined. Many of the avenues open to the sick, however, were closed to Donald Cowart. His eyes and hands were of no use. As with many burns patients his helplessness was emphasised by prolonged nakedness. His body was pain-full and alien to him as he dealt with those who cared for him.

Caring is grounded in the vulnerability of the other. In situations of vulnerability the carer is required to accompany the patient in his experience of pain, loneliness and isolation. One of the most basic loyalties owed to another is the loyalty of watching, waiting, keeping company, standing by, and giving care in times of sickness, pain and dying.[118] The usual elements entailed in caring were thwarted in the case of Donald Cowart since touch and sight were absent. The very extreme situation of his suffering highlights the embodied nature of care. Not only is caring expressed in words, it necessitates sight and touch as well. Touch is a more compelling form of contact than either sight or hearing because it is the symbol of vulnerability. In the caring relationship, the body is regarded - and touched - by the carer as the immediate, lived reality of the patient. This entails a breach of objectivity. Empathetic touch affirms, rather than ignores, the subjective significance of the body for the patient. Its purpose is not simply to palpate or manipulate but to express the carer's participation in the patient's experience. The caring relationship not only overcomes the objective character of the body by touching the patient, it is also able to alleviate the isolation that may occur within the person of the patient. In the caring relationship, the subjectivity of the patient is assumed to be as whole and valid as that of the carer.[119] Thus, in the act of caring the carer is directed to the whole person who is bodily present as the focus of care.[120]

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[117] This story is taken from Sally Gadow, "Covenant Without Cure: Letting Go and Holding on in Chronic Illness" in *The Ethics of Care and the Ethics of Cure: Synthesis in Chronicity*, edited by J. Watson and M. A. Ray, (New York: National League for Nursing, 1988), 5-14

[118] Cf. P. S. Keane, *Health Care Reform. A Catholic View*, (New York: Paulist Press, 1993), 81

[119] Cf. S. Gadow, "Nurse and Patient: The Caring Relationship" in *Caring, Curing, Coping. Nurse, Physician, Patient Relationships*, edited by A. H. Bishop and J. R. Scudder, (Alabama: University of Alabama Press, 1985), 31-43

[120] Richard McCormick notes that "[u]nless prevention, cure, and care are experienced as extensions of genuine human caring and love, they are less than they could be. They do not touch the whole person; rather, they minister to a body. They may heal a body, but we long for and need a deeper healing from each other as the body is healed, or even at times if it is to be healed." R. A. McCormick, "Some Neglected Aspects of the Moral Responsibility for Health" in *How Brave a New World? Dilemmas in Bioethics*, (London: S.C.M. Press, 1981), 43

The tragic circumstances of Donald Cowart's existence make evident the experiential intensity of the act of caring for a vulnerable human being. It is fair to assume that a qualitative difference occurred in the care Donald's nurses offered him as they accompanied him on his journey to healing. Persons who have no first hand experience frequently lack the feeling, emotion and passion entailed in the morally responsible task of caring for another.[121]

2.3.2 Explaining the Experience of Care

2.3.2.1 The Notion

Reference was made to conflicting understandings of care. Care, medical care and cure were pictured as Russian dolls fitting one inside the other. The ordering as to which is the largest through to which is the smallest is disputed. On that account it is necessary here to clarify the notion of care, its history and the ordering of the three notions of care, medical care and cure, so that an understanding of care may be achieved which assists in the analysis of just health care for the elderly. In many cases, given the scope of this thesis, an encyclopedia of a particular field of scholarship is cited as a shorthand indication of the scope of the field. In this section, for example, the *Encyclopedia of Bioethics* and *A New Dictionary of Christian Ethics* are each regarded as representative of their fields. Four meanings of the word *care* have been proposed by Warren Reich in the *Encyclopedia of Bioethics*: (1) primarily the word indicates anxiety, anguish, or mental suffering; (2) it is used to express basic concern for people, ideas, institutions and the like - the idea that something matters to the one who is concerned; (3) it may entail solicitious, responsible attention to tasks - taking care of the needs of people and one's own responsibilities; (4) it includes caring about, having regard for, or showing attentive care for a person, for his or her growth. Reich suggests that the "truly caring health professional is one who worries about - is concerned about - his or her patients, especially the patients who cannot take care of themselves."[122] James Childress distinguishes care into (1) "caring for" which involves attitudes and motives of compassion and mercy; (2)

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[121] Cf. McCormick, "Some Neglected Aspects...," in *How Brave a New World?* 45

[122] Reich, "Care. I. History of the Notion of Care" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 1. (New York: Simon & Schuster Macmillan, 1995), 329. Edmund Pellegrino distinguishes four senses of the word *care*: (1) care as compassion, (2) caring as doing for others what they cannot do for themselves, (3) taking care of the medical problem, (4) carrying out all the necessary procedures, personal and technical, with conscientious attention to detail, with perfection. The last two meanings fall under the notion of *competence*. "Integral care - that is to say, care that satisfies the four senses I have defined - is a moral obligation of health professionals." Pellegrino, "The Caring Ethic...," in *Caring, Curing, Coping.* 13

"taking care of", which involves effective actions often, but not always, out of the motive of care; (3) the moral and legal requirement of "due care" which dictates at least minimally how caring for and taking care of others should be carried out.[123] Both approaches to the notion of care suggest a certain ambiguity in the use of the word. It indicates (1) an attitude, feeling or state of mind in the person who cares, (2) it is the correlative of a level of competence, (3) it is context dependent requiring further specification in relation to particular roles, principles, expectations or institutions.[124]

In light of this ambiguity in the notion of care it is important to distinguish it clearly from its cognates, *compassion* and *sympathy*. Compassion has its roots in religious language and refers to "the emotional attitude or perspective that should shape and inform the appropriate response of religious believers to the suffering of others."[125] Compassion refers primarily to the attitude or disposition to identify with and respond to another's suffering, whereas a substantive notion of care requires one to specifiy more fully the object of compassion in particular circumstances. Sympathy, on the other hand, became a central component of the post-Enlightenment moral theories of Butler, Hume, Adam Smith and Schopenhauer and came to refer to the felt concern human beings experience for another person's welfare.[126] In this sense the notion of sympathy points to the natural source of human connectedness that grounds the sense of moral obligation within the human community.

2.3.2.2 History

Warren Reich, in his interesting historical study of care, notes that the Latin term *cura* as used in ancient Rome had two fundamental but conflicting meanings. First, it meant worries, troubles or anxieties, as when one says that a person is burdened with cares. Second, care meant providing for the welfare of another. Closely linked with this meaning was the positive connotation of care as attentive conscientiousness or devotion. These two conflicting aspects of care, namely care-as-burden and care-as-solicitude, were influential in thc Gracco-Roman myth called "Care". More than any

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[123] J. F. Childress, "Care" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: S.C.M., 1986), 77-78.

[124] S. Hauerwas, "Care" in *Encyclopedia of Bioethics*, edited by W. T. Reich, Vol. 1. (New York: Free Press, 1978), 145

[125] B. A. Lustig, "Compassion" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 1, (New York: Simon & Schuster Macmillan, 1995), 442

[126] Cf. E. Sprague, "Moral Sense" in *The Encyclopedia of Philosophy*, edited by P. Edwards, Vol. 5, (New York: Macmillan and The Free Press, 1967), 385-387; E. Radcliffe, "Moral Sense Theory" in *The Cambridge Dictionary of Philosophy*, edited by R. Audi, (Cambridge: Cambridge University Press, 1996), 512

other single source, this little known myth has given shape to the idea of care in literature, philosophy, psychology and ethics down through the centuries. In the story Care picked up some mud and began to fashion a human being. Care asked Jupiter to give the spirit of life to the human being which he readily did. Care and Jupiter then argue as to who should name the human. In the midst of this Terra arose and claimed the naming right since she had given her own body for the creation of the human being. Finally, all three disputants accepted the judgment of Saturn who decreed that Jupiter should take back the soul after death and Terra the body. Since Care first fashioned the human being she was to possess it as long as the human lives.[127] The meaning of the word *care* in this myth reflects a Stoic interest in uplifting, attentive solicitude. The word *care*, however, is not without tension since the lifelong care of the human entails both an earthly, bodily element that is pulled down to the ground (worry) and a spirit-element that strives upward to the divine. The positive side of care dominates in this story, for the primordial role of Care is to hold the human together in wholeness while cherishing it. The Myth of Care, furthermore, conveys an understanding of how care is central to what it means to be human and to live out a human life. It provides an aetiology of care that contributes to a rethinking of the value of care in human life.

Historically, understanding of care developed through the practice of the *care of souls*. The latter was offered to troubled persons whose difficulties, whether spiritual, mental or physical, were approached in the context of the pursuit of religious goals or in the search for ultimate meanings. The care-of-souls tradition has influenced the origins and content of contemporary ideas about care. The word *care* in care-of-souls refers both to the tasks involved in the care of a person or group and to the inner experience of solicitude or carefulness concerning the object of one's care.[128] The care of souls was often referred to as the *cure* of souls. In this it reflected an emphasis throughout history on a comprehensive idea of healing. Contemporary language refers to this as the *care of the whole person*. However, it is important to note that care-of-souls presupposes a hierarchy of values. The values indicate what humans cared about. Preeminent among these values was the spiritual. Closely related to this was an emphasis which concerned itself with the subjective experience of those who suffer and who call for relief in the form of personal attention.[129]

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127 Reich, "Care. I...," in *Encyclopedia of Bioethics*, 320

128 Reich, "Care. I...," in *Encyclopedia of Bioethics*, 321

129 Ps.142: 4-5, "I looked...and beheld, but...no man cared for my soul." Mt.11:28-30 shows Jesus solicitous care for the burdened. See also Mt.6:25-34. Reich notes that care of souls writings produced three major bodies of literature: (1) casuistry applied by the priest to the penitent in the confessional, (2) consolation literature offering sympathy for the ills of life, suffering and

With the 19th. century thinker, Soren Kierkegaard (1813-1855), care takes on a central role in human existence. It is viewed as the key to human authenticity. Kierkegaard introduced notions of concern, interest and care to counteract what he considered was an excessive objectivity present in the philosophy and theology of the post-Enlightenment period. At the same time Kierkegaard took the understanding of care in a new direction "by turning the subjective experience of worrrisome care into reasons for caring for one's self and seeking the care of others."[130] Martin Heidegger (1889-1976) built on Kierkegaard's approach making *care* the centre of his philosophical system of thought. Using the term *Dasein* (literally, "being there") to represent the human experience of being in the world through participation and involvement, he sought to show that it is care that accounts for the unity, authenticity and totality of the self, that is, of *Dasein*. Care (*Sorge*) summons the self (*Dasein*) back from the feeling of insignificance and anxiety found in flight from the self. It enables us to be ourselves, namely authentic. Anxious, worrisome care (*Sorge*) represents our struggle for survival and for favourable standing before our fellow human beings. There is also in daily life a "caring for" (*Fürsorge*) which expresses solicitude for and nurturing of others. Heidegger contrasts *Besorgen* (taking care of, in the sense of supplying the needs of others) with *Fürsorge* (solicitous care). Through these clarifications Heidegger has influenced the understanding of care as it is being used currently in contemporary health care and bioethics.

2.3.2.3 Medical Care

The ambiguities in the mythological and philosophical history of the term *care* have carried over into the notion of *care* in the medical arena. Stanley Hauerwas has sounded the alarm about the moral ambiguity of the term *medical care*. It may well be that the injured and the ill should be cared for, but it is by no means clear that medicine offers the best or only way to care for them. "Whether the *care* that medicine can provide should be provided will depend on the kind and extent of the medical skill that has been developed."[131] Paul Ramsey has argued that care is not meant to provide a basis for judgment for specific actions in the medical context. Rather, he regarded care as the source of all particular obligations, one's court of final appeal for deciding the features of actions and practices making them right or wrong. Many, however, doubt whether *care* alone and of itself can generate the kind of detailed guidance for medical professionals which Ramsey considered it implies.

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persecution (cf. Seneca, Plutarch, Cyprian, Ambrose), (3) *ars moriendi* literature commending the art of dying well and advising how to help the dying person.

130 Reich, "Care. I...," in *Encyclopedia of Bioethics*, 323

131 Hauerwas, "Care" in *Encyclopedia of Bioethics*, 146

It is important to note the ways in which *medical care* functions as a short-hand expression for a number of different things. First, emphasis on care as a morally significant notion for medicine often serves to emphasise that patients have needs that are other than strictly medical. The obligation is to treat the whole person. Second, that the doctor must *care* does not mean just that the patient should be given personal care, but that the doctor has a commitment to each individual patient that is not and cannot be overidden by any other consideration.[132] Third, competence "in the sense of a disciplined understanding of the science and skilled manipulation of the art [of medicine]," has been regarded as the first virtue of medical care.[133] In modern times, competence has become the essential and comprehensive virtue of medicine.[134]

The commitment to care for the individual patient is certainly an important, perhaps even crucial, commitment for medical ethics. A difficulty with this, however, is that such a commitment in itself is inadequate for resolving such complex matters as the just allocation of scarce medical resources. Nor is it sufficient for determining the ethical guidelines as to how statistical lives, random clinical trials, and the risks that are inherent in the development and practice of normal medicine are to be assessed. For these reasons the kind of care offered by medicine should not be limited to the needs of the individual patient.[135] In the light of such limits in the notion of medical care it is puzzling why the notion of care has not become better known and has not exerted more influence in ethics, in view of its highly significant yet somewhat limited history.[136]

2.3.2.4 An Ethic of Care

Feminist scholars have given momentum to contemporary re-evaluations of the notion of care.[137] Virginia Sharpe is among a number who have utilised the work of

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132 Hauerwas, "Care" in *Encyclopedia of Bioethics*, 146-147

133 A. R. Jonsen, *The New Medicine and the Old Ethics*, (Cambridge, Mass.: Harvard University Press, 1990), 22

134 W. T. Reich, "Care. II. Historical Dimensions of an Ethic of Care in Health Care" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 1, (New York: Simon & Schuster Macmillan, 1995), 332

135 Hauerwas, "Care" in *Encyclopedia of Bioethics*, 148

136 Reich, "Care. II...," in *Encyclopedia of Bioethics*, 329

137 Feminist ethics is primarily concerned with rejecting and ending the oppression of women. The focus here is political with a concern to eliminate oppressive imbalances of power. A group of feminists pursue a *feminine ethic* which attempts to describe the moral experiences and intuitions of women, pointing out how traditional approaches have neglected to include women's perspectives. Many of the authors considered in this section write from the perspective of feminine ethics. Cf. N. S. Jecker and W. T. Reich, "Contemporary Ethics of Care" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 1, (New York: Simon & Schuster Macmillan, 1995), 338-339. Gilligan, Noddings and Ruddick are counted among

Carol Gilligan as a starting point for developing an *ethic of care*.[138] She follows Gilligan in challenging the deontological theory of moral development proposed by Lawrence Kohlberg.[139] Sharpe distinguishes her *ethic of care* from what she calls a *justice oriented ethic*. In order to understand and evaluate her proposed ethic of care it is necessary to appreciate the central elements of a justice oriented ethic.

Gilligan's empirical criticism of Kohlberg is based on the fact that his research ignored the learning pattern of females and concentrated solely on that of males. For this reason Kohlberg's account of the essential attributes of moral learning has been judged as extremely partial.[140] This issue, while important and valid in itself, does not require further attention here. Rather, it is Kohlberg's rationale for moral development, with justice as its centre piece, that is relevant to this study. Kohlberg's thinking builds on two assumptions: (1) a liberal notion of justice and (2) a particular understanding of moral development.

Kohlberg's approach is grounded in the central assumption of liberalism, both classical and contemporary, that all individuals are the equal possessors of natural rights and liberties. Individuals have political rights on the basis of these *essential* attributes (rather than any arbitrary social, economic or personal ones). Kantian deontology, as a philosophical anchor of liberalism, provides the basis for much contemporary understanding of human autonomy and the requirement for an impartial point of view in moral analysis. One central difficulty with a justice-oriented moral theory is that it takes the relationship between the individual and society (or the state) as the paradigm of moral association. The constraints governing this association are extended to all other forms of human relationship. Justice theories fail to account for the moral bases of particular relationships whose survival depends on a greater involvement than impartiality and mutual non-interference can secure. These relationships include asymmetrical helping relationships such as those between doctors (or nurses) and patients, between teachers and students, as well as affiliations of intimacy and mutuality such as that enjoyed in friendship and family

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proponents of a feminine ethics. Cf. K. Lebacqz, "Feminism" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 2, (New York: Simon & Schuster Macmillan, 1995), 808-818

[138] C. Gilligan, *In a Different Voice. Psychological Theory and Women's Development*, (Cambridge, Mass.: Harvard University Press, 1982)

[139] V. A. Sharpe, "Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics", *Theoretical Medicine* 13 (1992): 296; cf. V. A. Sharpe, "How the Liberal Ideal Fails as a Foundation for Medical Ethics or Medical Ethics 'in a Different Voice'." Ph.D. Dissertation, Georgetown University, Washington, D.C., 1991

[140] Cf. C. Dykstra, "Kohlberg's Juridical Ethics: A Critique" in *Vision and Character. A Christian Educator's Alternative to Kohlberg*, (New York: Paulist, 1981), 7-29

relationships. The liberal view emphasises universalisability, impartiality and autonomy. These are seen to be the necessary conditions for a moral judgement. Where these elements are present individuals will be protected from all forms of discrimination made on the basis of arbitrary attributes such as social, economic or personal status.[141]

Piaget's stage-theory of cognitive development is fundamental to Kohlberg's theory of moral development. Both thought that the maturing individual proceeds in a dialectical manner through an invariant sequence of stages of moral development. Gilligan objected to this and has maintained that Kohlberg's approach is flawed at the level of theory. Because Kohlberg construes individuals narrowly as generic bearers of rights, morally significant relationships are characterised by reciprocity and equality. Insofar as justice is blind, the moral point of view must be one of impartiality. The commitment to impartiality requires that moral theory as well as moral practice remain indifferent to the specific aims and identities of persons. In the service of fairness and impartiality, moral judgments must be principle-driven and dispassionate. From the perspective of specifically deontological liberalism, impartiality and universality are best served by a theory that imposes no general conception of the good on individuals. For this reason, deontological theory gives priority to the right (the universally agreed-upon procedural principles of morality) over the good however it is articulated. These assumptions favour process and disregard many of the features that are distinctive of healing relationships.

A care perspective, however, stands in clear opposition to a moral domain characterised by the demands of equality, impartiality and universality. Because nurturing behaviour and the disposition to care have been regarded as inescapably *natural* they have not, in the liberal environment, been credited with or encouraged as moral skills. The care perspective

> finds moral salience in forms of human relating and responsiveness that arise between human beings who are seen by each other as precisely the *particular* unique human beings whom they are, rather than as abstractly conceived rights bearers. As a result, the care perspective allows for partiality as a legitimate moral point of view. In addition, because the care perspective is attentive to real individuals rather than simply to individuals abstractly conceived, it acknowledges the moral significance of real inequalities that may in fact distinguish us.[142]

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141 Two criticisms of this approach should be noted here. First, while formal equality may be stressed a denial of the material inequalities that distinguish persons in society is overlooked. Second, the narrow view of the self as either autonomous or the *locus* of utility makes no demand for the development of moral character. Cf. Sharpe, "Justice and Care...," 297-299

142 Sharpe, "Justice and Care...," 296-297

The essential difference between a justice and a care perspective resides in the different emphases they place on the dual notions of *self* and *relationship*. In the justice perspective the individual is the moral starting point, in the care perspective relationships are primary. The moral dimensions of Gilligan's work may be characterised as four-fold. First, the central function of morality is the cultivation of traits of character and a sense of personal responsibility that will guide persons in their relationships with others. As such, the quality of personal responsiveness to others is of paramount importance. Second, the primary task of moral responsiveness is to see others as singular concrete individuals with unique histories and desires. Responsiveness thus requires a moral point of view that is characterised by partiality. Third, moral response is called forth by the needs of others and the ability to meet those needs through acts or omissions. These needs may be explicitly articulated or may be implied by the very nature of an unequal or dependent relationship. Fourth, morally good caring requires the cultivation of desirable forms of emotion that will allow people to discern and respond to the needs and concerns of others. This understanding of the care perspective would seem more akin to an Aristotelian virtue-based approach to moral deliberation and development.[143]

The care perspective, therefore, is oriented to individual needs that arise within particular relationships. Of utmost importance here is a thorough understanding of the nature of the relationship in which the parties are involved. This entails (1) the expectations, desires and/or fears that caused the parties to come together in the first place, (2) the goods that the parties regard as attainable only through the cooperation afforded by the relationship, and (3) the relative power of the parties in the relationship. Thus a care-oriented medical ethic more broadly encompasses forms of human attachment and responsiveness, such as care, concern and sensitivity, which appear to be absent in impartialist theories.[144]

An ethic of care has been subjected to numerous criticisms.[145] The most significant suggestion has been that an ethic of care should be viewed preferably as a broad human ethic rather than as an ethic that expresses an exclusively feminine form of

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[143] Sharpe, "Justice and Care...," 303

[144] Sharpe, "Justice and Care...," 313. Carse observes that care reasoning "introduces a conception of moral psychology much thicker and richer in its skills and capacities than the conception needed on the justice perspective and suggests a movement in a more virtue-theoretic direction, in which not only our actions, but also our characters, are a focus of moral attention." A. L. Carse, "The 'Voice of Care': Implications for Bioethical Education", *The Journal of Medicine and Philosophy* 16 (1991): 17-18

[145] Jecker and Reich, "Contemporary Ethics of Care", in *Encyclopedia of Bioethics*, 339-340

moral reasoning.[146] The proposal has merit particularly in light of recent analyses of care which emphasise the subjective dimension of caring (Noddings) in contrast to a more objectivist portrayal (Ruddick). Each of these approaches may be located at extreme ends of a continuum of views regarding the nature of care and an ethic of care. Nel Noddings distinguishes between *caring* as an attitude and *caretaking* which involves concrete actions of personal assistance.[147] Noddings privileges the moral significance of the former over concrete caring labour.[148] At the other end of the spectrum from Noddings' emphasis on care-as-subjective-attitude is the work of Sara Ruddick who argues that the moral work of caring "'does not require enthusiasm or even love; it simply means to see vulnerability and to respond to it with care rather than abuse, indifference, or flight.'"[149] Certainly, it is important that many caretakers recognise care as a moral duty irrespective of subjective feeling, rather than as something necessarily motivated by loving sentiments. A middle way between subjectivist and objectivist notions of caring may be found in an understanding of caring relationships that emphasises reciprocity, mutuality or human interdependence. Such an ethic would attend more actively to modes of relating to and being with others. This helps to sustain relationships between individuals who are unequal in power and relatively dependent.[150]

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[146] This point has been well made by Bill Puka when he notes that Gilligan's studies emphasise (1) socialisation, reflective consciousness-raising, and coping more than moral development; (2) gender-based coping more than a care theme of coping which women happen to prefer, and (3) coping with oppression and especially sexism rather than more general coping with moral issues. B. Puka, "The Liberation of Caring; A Different Voice For Gilligan's 'Different Voice'", *Hypatia* 5:1 (1990): 67

[147] Cf. N. Noddings, *Caring. A Feminine Approach to Ethics and Moral Education*, (Berkeley, Ca.: University of California Press, 1984); N. Noddings, "A Response", *Hypatia* 5:1 (1990): 120-26.

[148] Four criticisms have been levelled at Nodding's analysis of care. (1) Her description of the act of caring is unidirectional. Using the mother-child relationship as a paradigm Noddings promotes the "infant non-reciprocity-beyond-acknowledgement as a model for ethically relating to others." This is inadequate for the range of care relationships experienced through life. (2) Questions can be raised about the sense of self that emerges from Noddings' analysis of the one who cares. (3) She sees withdrawal from a relationship as the diminishment of an ethical ideal. There are times, however, when withdrawal is necessary in order to sustain the ideal. (4) The non-judgmental approach in the one who cares that dominates in Noddings' approach is open to criticism. Care is a much more hard-headed reality in human relations. Cf. S.L. Hoagland, "Some Concerns About Nel Noddings' 'Caring'", *Hypatia* 5:1(1990): 110-112

[149] B. H. Andolsen, "Justice, Gender, and the Frail Elderly. Reexamining the Ethic of Care", *Journal of Feminist Studies in Religion* 9:1-2 (1993): 136

[150] Carse, "The 'Voice of Care'...," *The Journal of Medicine and Philosophy*, 17

2.3.3 Implications of Care

An ethic of care has a number of implications for an understanding of health care. In exploring these implications the weaknesses of the feminine approach (as defined in n.137 above) that have been raised by feminist thinkers must not be overlooked. Two implications of a care ethic merit attention at this point: (1) a care orientation within bioethics requires greater emphasis to be placed on beneficence as the health provider's primary responsibility to the patient, and (2) a care ethic may result in substantive changes to the way moral problems are resolved.[151] In fact the "emergence of feminine ethics can play an important role in reemphasizing the value and importance of caring within medicine."[152]

Within health care attention to caring is perhaps most evident within nursing.[153] The tendency to associate caring exclusively with nursing is, however, misleading. Certain meanings of curing are derived from caring. Caring itself, at least in theory, is inextricably linked to the doctor's obligation to relieve suffering, a goal that stretches back to antiquity. The connection between cure and care is, however, being fractured in contemporary medical practice. The narrow focus of modern scientific medicine on curing, and the priority it gives to scientific and technical remedies, has undermined the role of care in actual medical practice. The increasing prevalence of contractual medicine and the defensive practice of medicine in a litigious environment have diminished the role of caring implicit in the Samaritan principle which has dominated much of Western medical care until recently.[154]

At present urgent questions of social justice associated with care for the frail elderly are being avoided because many societies rely on the moral generosity of women who have been socialised to put the needs of vulnerable family members first. One place where an ethic of care and an ethic of procedural justice may intersect helpfully is at the point where the *other* and the *self* are included in the network of care. Attention must be given to the question of social justice and the obligation of the good society to provide support and care not only for the frail elderly but also for

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[151] Jecker and Reich, "Contemporary Ethics of Care" in *Encyclopedia of Bioethics*, 337

[152] Jecker and Reich, "Contemporary Ethics of Care" in *Encyclopedia of Bioethics*, 342

[153] Sara Fry argues "that caring ought to be the foundational value for any theory of nursing ethics. In addition, caring must be grounded within a moral-point-of-view of persons rather than any idealized conception of moral action, moral behavior, or system of moral justification." S. T. Fry, "The Role of Caring in a Theory of Nursing Ethics", *Hypatia* 4:2 (1989): 89. An argument has been made that the notion of caring should shape the description, rationale and methodology of nursing as a profession. Cf. Jecker and Reich, "Contemporary Ethics of Care" in *Encyclopedia of Bioethics*, 340

[154] Cf. Jonsen, *The New Medicine...*, 38-60

family members. The act of caring must not harm the care-giver. In ignoring such social justice questions, it is argued, an ethic of care is especially vulnerable. The contribution of Carol Gilligan and Nel Noddings is not helpful in the social justice arena. They are primarily interested in personal moral choices and pay scarce attention to social justice questions.[155] Furthermore, efforts must be made to guard against a rhetoric of care associated with family values. This frequently serves to limit government spending on social welfare and to impose family care of the elderly. An ethic of care may ultimately be judged inadequate since it narrowly configures care to the dyad of the *one caring* and the *one cared for*. In doing this it ignores the wider social implications of care.[156]

The care of the elderly and the dependent in society has had a fascinating history. In the United States of America, beginning in the 1820s, a wave of welfare reform overturned prevailing assumptions and practices. Crime, mental illness, poverty and ignorance came to be thought of as remediable conditions. Ironically, the growth of democracy and egalitarianism in the U.S.A. was accompanied by growing uneasiness in the face of social differences, an uneasiness that led to policies designed to compel or persuade all members of society to conform to a single standard of citizenship. Institutionalised segregation of the poor in almshouses was based on the view that a clear distinction could be made between the *worthy* poor and the *unworthy* or able-bodied poor. This line of thought prevailed at the time also in Australia.

As noted in the consideration of aging earlier, the consensus of the Victorian era was that any person who lived a life of hard work, faith and self discipline could preserve health and independence to a ripe old age. The shiftless, faithless and promiscuous, however, were doomed to premature death or a miserable old age. As with the distinction between the *worthy* and *unworthy* poor, this dualistic vision of old age served the ideological function of blaming the victim. Individuals unwilling to save for old age or not committed to following the bourgeois regimen of temperance and virtue should not expect to be supported with pensions in their old age. The pessimism of the late nineteenth century was coupled with the view of medicine which saw old age as a period of inevitable, unrelieved deterioration. This view also justified the exclusion of the elderly from general hospitals and insane asylums. By 1935, however, the prevailing myth of healthy self-reliance had been replaced by its opposite - the aged were considered sick, poor, and unable to support themselves. During the 1960s the nursing home emerged as the primary long-term care setting for

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155 Andolsen, "Justice...," *Journal of Feminist Studies in Religion*, 142

156 Andolsen, "Justice...," *Journal of Feminist Studies in Religion*, 145

the elderly and came to be viewed as expressing this new understanding.[157] An appreciation of these historical shifts is important when considering chronic illness and long-term care. Being elderly frequently cntails both.

The twentieth century has produced a striking epidemiological transition from a population whose morbidity, disability, and death profile was characterised by acute conditions to a profile dominated by chronic conditions. People now live longer lives but in worsening health. In fact older persons are likely to have multiple chronic conditions (comorbidity). A chronic condition is one that has lasted or can be expected to last for a long time, defined variously in health statistics as three months, six months, or twelve months.[158] Arthritis is the leading chronic condition for the middle aged and the elderly. Frequently, disability which accompanies chronic conditions has an impact on the function of specific body systems and on an individual's ability to act in necessary, expected and personally desired ways in his or her society.[159] This experience of chronic conditions by increasing numbers of people in an aging society has necessitated the development of long-term care.

This type of care entails a set of health, personal care and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capacity. In lay terms, long-term care is the assistance that is needed to manage as independently and as decently as possible when disabilities undermine capacities.[160] In general, individuals requiring long-term care are an heterogeneous group. However, they are more likely to be frail, to carry a heavy burden of illness, to be among the oldest old, to suffer functional impairment, to be impoverished, to be dependent on others, to be found in institutional settings and to face constrained choices in daily living.[161] Long-term care is, in fact, a hybrid of

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[157] T. R. Cole, "Class, Culture, and Coercion. A Historical Perspective on Longterm Care", *Generations*, 11:4 (1987): 10-14

[158] L. M. Verbrugge, "Chronic Care" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 1, (New York: Simon & Schuster Macmillan, 1995), 378

[159] Note that the "term *handicap* indicates social disadvantages that people with disabilities experience, namely, restrictions on doing what they can and wish to do because of social conventions, ranging from attitudes to laws, or because of environmental barriers." Verbrugge, "Chronic Care" in *Encyclopedia of Bioethics*, 379

[160] R. A. Kane and R. L. Kane, "What Is Long-Term Care?" in *Long-Term Care. Principles, Programs, and Policies*, (New York: Springer, 1987), 4. See also R. A. Kane, J. A. Rhymes, L. B. McCullough and T. Wetle, "Long-Term Care" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 3, (New York: Simon & Schuster Macmillan, 1995), 1377 where long-term care is defined as "an individualized mix of health-care, personal-care, and social services for persons whose functional impairments dictate that they receive help with tasks of everyday living."

[161] T. Wetle, "Long Term Care. A Taxonomy of Issues", *Generations*, 10:2 (1985): 30

health and social services. Frequently, functional impairment triggers the need for long-term care. Such care is provided initially in the family context. When others outside the family are engaged in the care of a family member the work involved is often intensive yet relatively unspecialised. It needs, however, to be flexible so as to be responsive to the needs of the impaired person.[162] Any detailed analysis of long-term care must pay due attention to the individual who receives the care, his or her family, the service providers and the system that provides the assistance.[163] As noted in chapter 1, the locus of long-term care in Australia is the nursing home. A number of factors relating to this type of care have been discussed there.[164]

Three aspects of long-term care of the aged remain to be mentioned here since they have a bearing on the type of care to be offered to aged persons. First is the issue of human dignity. It has been suggested that the problem for the elderly in today's world is "how to live and age in dignity in a society that is in love with youth, embarassed by age, and frightened by death."[165] The degree of dignity given to persons in contemporary society is in proportion to the range of their power. Because the range of autonomy in the elderly has been narrowed by enforced retirement, reduced economic circumstances, and loneliness the respect they receive tends to be slight. This loss of dignity and power is sensed by the elderly and frequently experienced in a dramatic way as sorrow, depression, feelings of worthlessness. Consequently, how the elderly struggle to retain their dignity and power is important. They employ various tactics to shore up their dignity in the face of society's increasing indifference to them.[166] They either become defiant or grow to recognise

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162 Kane and Kane, "What Is Long-Term Care?" in *Long-Term Care*, 6-9

163 In the analysis of family, service providers and the system Wetle notes a number significant matters: (1) regarding the family there are (a) shifts in dependency relationships; (b) confusion of values regarding appropriate support by family members for those in long term care; (c) intergenerational responsibilities. (2) Regarding service providers the following should be considered (a) role definitions and conflicts; (b) paternalism vs. autonomy; (c) special risks of institutional settings; (d) placement, discharge planning and involuntary commitment; (e) decisions to withhold treatment; (f) quality of life considerations. Finally, (3) concerning the system attention must be paid to (a) institutional bias in public funding; (b) policy and practice which conflict; (c) cost containment; (d) profit making in health and social services; (e) age discrimination. While these are American issues a good number are applicable in the Australian scene. Wetle, "Long Term Care...," 31-34

164 For a survey of some of the ethical aspects of nursing home care see B. Collopy, P. Boyle and B. Jennings, "New Directions in Nursing Home Ethics", *The Hastings Center Report* 21:2 (1991): S.1-S.15; Moody explores some of the ethical dilemmas in nursing home placements in H. R. Moody, "Ethical Dilemmas in Nursing Home Placement", *Generations* 11:4 (1987): 16-23.

165 G. A. Kanoti, "Needed: A Geriatric Ethic" in *Biomedical Ethics*, 2nd. ed., edited by T. A. Mappes and J. S. Zembaty, (New York: McGraw-Hill, 1986), 168

166 Kanoti, "Needed...." in *Biomedical Ethics*, 169

the reality of human interdependence and in the process achieve a degree of serenity.[167]

Space is the second important factor in long-term care. Space and the designing of long-term care facilities must be a high priority in the care of the elderly. Successively and progressively, disease, impairment, old age, immobility, and death restrict one's experience of space. The world at large reduces to a single room and ultimately to a coffin. Ordinarily people live in a number of different environments - home, workplace, streets, parks, gardens, and shops. For the young and middle aged the bedroom is only part of a total world and, at times, a sanctuary from it. But for the immobile or the impaired their world shrinks to a single room. Designers of total institutions take on an awesome responsibility. They create for residents not just a fragment but the whole of their perceivable world. As their physical world is increasingly limited psychic life also shrinks. The elderly become increasingly preoccupied with the body and its troubles. Physical and psychic space thus tend to contract simultaneously. Sensitive reflection on the older person's perception of his or her body and the contracting world it inhabits are vital issues in constructing long-term care facilities.[168]

Third, it has been correctly noted that focusing on the ethics of care-givers results in a neglect of virtues appropriate to care-receivers. As will be noted later in considering philanthropy in medical care an imbalance can arise in the doctor-patient relationship. In the past health care personnel were defined as givers and the recipients of such care were indebted and often passive in their role as patient. The equality and reciprocity emphasised in much recent ethical literature and medical practice calls for a renewed interest in the virtues that age calls one to live. W.F. May has proposed a number of virtues appropriate to the elderly, namely, courage, humility and patience. He notes as well the marks of old age referred to in the Benedictine tradition - *simplicitas, benignitas* and *hilaritas* (simplicity, kindness and good cheer).[169] This attention to the virtues of care givers and receivers offers a timely reminder of the nature and complexity of the care relationship. Various aspects of this will be explored in the philosophical and theological analyses to follow.

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[167] Cf. D. Christiansen, "Dignity in Aging", *The Hastings Center Report*, 4 (1974): 6

[168] W. F. May, "Who Cares for the Elderly?", *The Hastings Center Report* 12 (1982): 34

[169] May, "Who Cares…," *The Hastings Center Report*, 36. The author notes that the New Testament in its table of duties is revolutionary, breaking with the Stoic tradition of addressing only the person in the superior position. In the New Testament the subordinate person, e.g. the wife, child or slave, is addressed as a moral agent.

2.4 SUMMARY AND CONCLUSIONS

2.4.1 Summary

In light of the gaps that exist in Australian aged care, chapter 2 introduced an alternative line of inquiry more attentive to the interconnecting network of factors involved in aging and health care. The humanistic emphasis focuses on a set of problematic human issues that arise with the fact of individual and societal aging. The central question of *meaning* concerns aging itself: What does it mean to grow old? Narrowly focused or reductionist explanations of senescence do not adequately address the fundamental human quest for the meaning of longevity. Closely connected with this question are two further problematic issues: What does it mean to be healthy or ill when one is aging? What does it mean to care when aging brings chronic illness, disability and long term questions of care? The issues of well-being and care have a different complexion and implications when elderly persons are involved. These three questions were explored in terms of three further questions: What is the human experience of aging, health/illness and care? How are the experiences of aging, health/illness and care explained? What are the implications of the experience and the explanations for the issue of just health care for aged Australians?

2.4.2 Conclusions

2.4.2.1 About Aging, Well-Being and Care

Chapter 2 has offered a comprehensive exploration of aging and related matters from the point of view of a humanistic inquiry. I argue that this material is more satisfactory than the somewhat narrow technical and pragmatic responses of Australian aged care policies. The mythic, cultural and historical notions of aging studied at the beginning of this chapter indicate a wider area of investigation. The way in which the life cycle and life span approaches have contributed to our understanding of human aging complemented the scientific, sociological and ethical explorations more commonly undertaken. Together they provide more broadly based and enriching perspectives on human aging and they sustain the following conclusions.

Regarding aging:

1. Undue emphasis on the experience of aging as frailty and decline and as involving loss of vitality masks important opportunities that are offered during this period of life. In fact it may be argued that these experiences have an importance and significance greater than those at any other time earlier in life. This chapter highlights the fact that aging presents an opportunity for cultivating a conscious integrity for the self as a bodily person. This enables the elderly person to value interiority and appreciate the sense of time and the place one has in the human story.

2. The experience of individual and societal aging should offer elderly persons meaningful and clear social roles in the contemporary world. Becoming an elderly person is intimately related to the values, expectations and structures of the wider community. Social and behavioural studies endorse this conclusion.

3. To portray aging as a problem effectively undermines the process of aging and the status of the elderly as a group in society. Approaching the phenomenon of human aging from the view point of mystery opens it up to the reflection exemplified by the humanistic approach used in this chapter. A problem perspective tends to favour a reductionist methodology and tricks us into thinking that adequate answers may be attained. The mystery perspective is necessitated not only by the reality of human aging but also by the plurality of meanings required by a liberal ethos.

Regarding well-being:

1. A psycho/social/somatic/environmental view of health

    - effectively de-medicalises notions of aging and health/illness, and

    - gives importance to the bodiliness of the aged person and his or her well-being; it focuses on the bodily character of the art of healing, on the physical presence of the professional health care giver and on the type of caring given and received.

2. Notions of health and illness are always imbedded in a network of community relationships. It will be shown in chapter 3 that they can never be adequately grasped in a health care system restricted to social contracts or professional codes.

Regarding care:

1. Caring for another demands both an attitude of mind, such as solicitous concern arising from fellow feeling (e.g. sympathy) and, at times, effective actions towards or on behalf of another. These long held elements of care are explored further in chapter 3.2 in terms of beneficence and still later in chapter 7.3 through the theological notion of charity.

2. The correct ordering of the different dimensions of care has direct implications for the type of care offered especially in health care for the aged. Where care is a central priority, medical care and cure have a subsidiary but important place.

3. The insights arising from contemporary explorations of an ethic of care emphasise the person-centred nature of human caring. It is fundamentally relational, demanding a personal responsiveness on the part of the carer and, where possible, on the part of the one cared for.

4. Degrees in caring must be delineated. The demands of caring for others within the family context, considered in chapter 5.2 in terms of intergenerational obligations, necessitate a more demanding level of care than may be expected of the care given in a public health care system.

5. The increasing incidence of chronic illness in an aging population has given high priority to caring for persons for whom there may be no cure. A mix of needs must be cared for involving health, personal and social needs. Care must be the central and umbrella concept organising professional and informal modes of care for aged persons.

6. Caring for aged persons implies an acknowledgement, at some point, that death is inevitable and that it must be accepted.

2.4.2.2 About Justice

This thesis is concerned with *just* health care for aged Australians. For this reason it is appropriate here, at the end of Part I, to advert to the fact that the first two chapters have raised important questions of justice. Brief reflection indicates issues of justice

pervading the analysis of the Australian scene in chapter 1 and all three questions of meaning in chapter 2.[170]

In chapter 1 the demography of an aging population suggest tension points between the young and the old in Australian society. Issues of justice arise in reference to the role of the elderly in the workforce and in regard to questions of retirement income, especially the age pension and superannuation benefits. It has been claimed that an aging population is placing unjust burdens on an increasingly smaller workforce who must make greater sacrifices in order to support the elderly in society. Furthermore, housing an aging population and providing health and community services for the elderly all offer tension points where considerations of justice must enter into public deliberation. In an era when severely restricted budgets make equitable distribution of resources all the more difficult, the challenge to act justly is ever present.

Throughout chapter 2 it was evident that particular understandings of aging, health/illness and care unduly penalise the elderly. Certain assumptions as to what it means to grow old deprive aged persons of the status, potential and fulfillment that is their due. Likewise, narrow perspectives on health, illness and care decisively influence what the aged person has a right to expect in justice within the human community.

The demands and scope of justice are central to what follows in Part II and Part III. In Part II recent bioethical analyses of justice, health care and the elderly are considered, particularly the proposals put forward by two American bioethicists, Norman Daniels and Daniel Callahan. Two justice issues are given detailed consideration in chapter 5: the policy proposal that there be an age criterion in the delivery of health care and the question as to the nature and scope of intergenerational obligations. An analysis of these same two issues will be undertaken in chapter 9 from a theological perspective.

2.4.2.3 Future Directions

Before commencing the bioethical analysis of Part II, I wish to foreshadow here three levels or strands of reflection that will be discerned running throughout the analyses of Parts II and III that follow. The first, or *political* level, derives from the fact that justice, health care and aging exist in a political context. In the Anglo-American context political liberalism is dominant. The ways in which both political theory and

[170] Justice is understood here to mean the giving to another person what is his or her due; for that reason it is the virtue sustaining right relations within the human community. Justice will be analysed in greater detail in chapters 3.1.2 and 8.3.

the political context dictate questions and answers concerning just health care for the elderly are of particular interest to this study. At the second or *general ethical* level the adequacy or inadequacy of the philosophical and theological approaches elaborated in Parts II and III are to be evaluated in terms of the way they contribute to a satisfactory understanding of just health care for the aged. The third or *specific issues* level attends to the experience of limits associated with the justice dimensions of particular types of health care delivery. Two "limits situations" discussed in recent bioethical literature provide the *loci* for the justice questions central to this thesis. Whether the conclusions about just health care for aged persons are congruent with and directly flow from the philosophical and theological frameworks elaborated will require testing. In reading what follows it is helpful to keep these three dimensions in mind since they permeate the philosophical and theological inquiry. They provide both filter and framework for arriving at the conclusions presented at the end of this thesis (Part IV, chapter 10.2). The political, general ethical and specific issues perspectives thus provide a useful way of viewing the substantive contributions arising out of the bioethical and theological analyses of Parts II and III. The three strands, however, will only be discussed explicitly in Part IV.

PART II

ETHICAL RESPONSE: RECENT BIOETHICAL ANALYSIS

Part II charts recent bioethical discussion in three stages. It moves from an understanding of the more general context of recent bioethical thinking in chapter 3, to the particular contributions of two American bioethicists in chapter 4 and then to consideration of two sharply defined issues of justice in chapter 5.

Chapter 3 introduces the political, health care and bioethical contexts that have shaped the work of two American bioethicists, Norman Daniels and Daniel Callahan. The notions of liberalism and justice underpinning American society introduce the chapter. The understanding of caring for the neighbour, influential in western medical practice, is explored in terms of beneficence, philanthropy, altruism and rights. This richly textured background leads directly to a consideration of the goals and limits of contemporary medicine and health care. The chapter concludes with a brief description of the particularities of U.S. health care and American bioethical analysis. Chapter 3 thus provides a detailed picture of the particular historical and cultural context of American health care sufficient to appreciate the contribution of Daniels and Callahan considered in the following chapter.

Chapter 4 outlines the conceptual frameworks that Norman Daniels and Daniel Callahan have adopted in addressing the issue of just health care for the elderly. Each author represents a dominant view of society and justice. Norman Daniels adopts the *atomist* view of liberalism and develops a Rawlsian account of just health care for the aged. Central to his argument is the principle of *fair equality of opportunity* regarding the social good of health care. His account also depends on a *prudential lifespan account* where goods to be distributed are computed over the human life-time. Daniel Callahan adopts the *social* view of communitarianism. His approach operates at two levels. At a philosophical level Callahan criticises the prevailing American "minimalist ethic". In its place he urges a general acceptance of limits in human life. At the policy level Callahan gives priority to *care* over *cure*. His argument gives great importance to the idea of the *natural life span* and the notion of a *tolerable death.* In the light of this Callahan proposes a public policy which sets an age limit to publicly funded, high technology, life-extending therapies.

The contributions of Daniels and Callahan outlined in chapter 4 exemplify two strands of philosophical and political thinking that have currency in recent bioethical discourse. Their approaches are brought into sharp relief in chapter 5, which analyses two significant questions of justice arising out of the experience of limits in the delivery of health care to aged persons. The first question is a public policy issue, whether an age criterion excluding certain categories of the elderly from receiving certain types of high technology health care should be introduced. The second, more philosophical issue arises from difficulties that many middle aged children have in caring for their elderly parents. This is the so called intergenerational obligations question: What is the nature and scope of this obligation? How do the two bioethical perspectives *justify* the commitments children have toward caring for aging parents and how do they *set limits* to obligations once these have been acknowledged?

I have indicated in the introduction to this thesis that the structure of Part II can be imagined as a funnel. It moves from the general context of chapter 3 at the top, through narrower contribution of Daniels and Callahan in chapter 4 to the narrow and clearly defined justice questions of chapter 5. The funnel shape of this part of the thesis expresses the three levels permeating this study mentioned earlier in chapter 2.4.2.3: the political level, the general ethical level and the specific issues level.

CHAPTER 3
THE CONTEXT OF THE BIOETHICAL DEBATE

3.1 Liberalism and Justice 121

- 3.1.1 The Liberal State 121
- 3.1.2 Justice 125
  - 3.1.2.1 Two Perspectives 127
  - 3.1.2.2 Rawls and the Communitarian Reaction 129
  - 3.1.2.3 Distributive Justice 133

3.2 Beneficence and the Right to Health Care 136

- 3.2.1 Beneficence 136
- 3.2.2 Philanthropy 139
- 3.2.3 Altruism 143
- 3.2.4 Code, Contract and Covenant 145
- 3.2.5 The Right to Health Care 147

3.3 The Goals and Limits of Health Care 153

- 3.3.1 The Goals of Medicine and Health Care 153
- 3.3.2 The Limits of Medicine and Health Care 157

3.4 U.S. Health Care and Bioethical Analysis 163

- 3.4.1 Health Care in the United States 163
- 3.4.2 American Bioethics 168

3.5 Summary and Conclusions 172

- 3.5.1 Summary 172
- 3.5.2 Conclusions 173

CHAPTER 3

THE CONTEXT OF THE BIOETHICAL DEBATE

Chapter 2 explored the basic concerns and problematic questions of meaning that arise in any human community as it confronts the concrete demands for just health care for the aged persons in its midst. These issues are foundational to any human reflection on health care for the aged. In this chapter the issues will be revisited but from within a particular historical and cultural context.

In the English speaking world the meaning of aging, health/illness and care has been made increasingly problematic because of the influence on the range of issues discussed in the bioethical literature since the 1970s of the political ethos and health care policies of the U.S.A.. In discussing the increasing number and proportion of aged people in the U.S.A. bioethicists have assumed at least three elements of the political and moral philosophical agenda prevailing in American culture. First, the particular shape liberal democracy has taken in the U.S.A. has emphasised the centrality of personal autonomy and choice; its capitalist ethos has favoured industry and productivity and its pragmatism has promoted clear cut solutions to the problems confronting health care such as rationing. These have had a direct impact on the meaning of aging in American society. Second, Americans have confronted the paradox of health, disease and illness in human life with an optimism about technology that drives their involvements at both the individual and corporate levels. The dominance of acute medicine not only answers some disease and illness problems but also proffers aggressive solutions to the less tractable issues of chronic illness, aging and death. Third, care has likewise become problematic in this milieu. A jaundiced eye has been cast on beneficence since it is very frequently judged to be paternalistic. Altruism is placed in tension with self-interest. Human relationships have been filtered through the language of rights. A libertarian community such as the U.S.A. must not presume too many specific goods. It functions best where contracts shape the demands of justice and where what is for the public interest presupposes an overlapping consensus of individual personal interests. The human commitment and fidelity of caring families, local communities and the wider society have been sorely tried by such forces.

These political, philosophical and ethical approaches have been so influential on the bioethical issues, analyses and policies discussed in English language literature during the last twenty five years that it is essential to consider them in some detail.

Chapter 3, therefore, provides some appreciation of the assumptions and experience that Americans bring to justice, health care and the aged. It is a necessary backdrop to the analysis of just health care for the aged to be developed in chapter 4, where the American authors, Norman Daniels and Daniel Callahan, are shown to represent two significant yet different approaches to the question of just health care for the elderly.

Chapter 3 unfolds in four, progressively particular, sections providing information that is necessary and useful for a better understanding of the work of Daniels and Callahan. The first section gives a brief outline of the dominant concepts of liberalism and justice. An understanding of the liberal state is essential for appreciating the priorities of contemporary American society. Within this milieu two strands of justice thinking are significant, the liberal contractarian account of John Rawls and the communitarian reaction to this dominant liberal account. Norman Daniels will later be seen to develop the Rawlsian account by applying it to health care issues. Daniel Callahan, on the other hand, has taken a communitarian approach to justice, health care and the aged.

Liberalism has influenced the practice of medicine during the last century, especially reforming the role beneficence plays in medical care. An increasing emphasis on the contractual dimensions of social relations has resulted in the traditional notions of beneficence, philanthropy and altruism being limited to codes of practice and greater emphasis being placed on the right to health care. These significant changes are the subject of the second section of chapter 3. Attention is, necessarily, given to the history of beneficence, philanthropy, altruism and rights in order to assess their status in light of the central issues of just health care for the elderly.

Against the backdrop of sections one and two, the third part of chapter 3 explores the goals of medicine and health care and the issues of distribution, allocation and rationing that flow from limited medical and health care resources. Finally, in section four, the particularities of U.S. health care and bioethics are briefly sketched. Daniels and Callahan have been significant contributors to the health care policy debate in the U.S.A. during the last quarter. The issues considered in this chapter have had an important influence on the way American scholars, particularly Daniels and Callahan, have developed their bioethical reflection. Furthermore, it is argued that the issues discussed in chapter 3 have been significant in the health care and bioethical analysis of recent times.

3.1 LIBERALISM AND JUSTICE

3.1.1 The Liberal State

The modernist agenda in political theory accepts, as fact and principle, the radical and irresolvable differences of opinion as to what is the good for human beings and what their ultimate nature should be. Many major liberal political theorists of the 1970s and 1980s explicitly abandoned the idea of an objective moral order which would define the *telos* of the human being. Some forms of liberal political theory abandoned the idea of basing an understanding of politics in the good life. Attention is given to those rules which secure to each individual the greatest amount of freedom to pursue his own good in his own way so long as he does not act unjustly and infringe the freedom of others.

The ethic of rules rather than goals or ends is the central characteristic of this form of liberalism and it is central to the coherence of the liberal project that these rules can be justified by arguments which do not make specific assumptions about epistemology, metaphysics, human nature or the good life. The problem for liberalism thus becomes one of determining the set of rules by which government can treat individuals with equal respect and, at the same time, not impose one particular conception of the good on them. Neutrality is a central value in liberalism and for its project to be coherent it has to show that the rules which define a liberal society can be derived from a position of neutrality in relation to differing conceptions of the good. Any form of legitimate state activity has to be undertaken within a set of rules which are arrived at in a neutral way and are directed to policies which are, as far as possible, neutral between different conceptions of the good life.[1]

Liberal political thought thus emphasises the freedom of the individual to shape his or her life according to each one's unique view of what is good. The view of human freedom espoused by liberal theorists is a negative one, namely freedom from external coercion. It, too, is to be viewed independently of any particular view of the values and positive ends which liberty can serve.[2]

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1 R. Plant, *Modern Political Thought*, (Oxford: Basil Blackwell, 1991), 75-77; M. Cranston, "Liberalism" in *The Encyclopedia of Philosophy*, edited by P. Edwards, Vol. 4, (New York: Collier Macmillan, 1967), 458-61.

2 Cf. W. A. Galston, *Liberal Purposes. Goods, Virtues, and Diversity in the Liberal State*, (New York: Cambridge University Press, 1991), 165-237 for a constructive discussion of liberal goods, justice and virtues.

A critic of contemporary liberalism has argued that it seeks to bring into existence a society in which a "tradition-independent moral standpoint" is attainable.[3] This has direct implications for communities which have substantive notions of the common good:

> Individuals are granted the freedom to have certain preferences and hold certain opinions (even religious ones), provided they are understood to be ultimately subsidiary to a liberal rationality that overrides the particularisms of contending traditions and individual points of view. There are different opinions as to where this rationality abides: it is variously located in the market economy, management, the new information industry, psychotherapy, the political process, and the legal system.[4]

Utilitarianism has exercised a considerable influence within modern liberal societies. There are two attractions in utilitarianism: it conforms to the intuition that human well-being matters, and to the intuition that moral rules must be tested for their consequences on human well-being.[5] Utilitarians have traditionally defined utility in terms best illustrated by the slogan "the greatest happiness for the greatest number". What constitutes human happiness is much disputed among utilitarian thinkers. Utility, human well-being or happiness is to be found, they suggest, in (1) the experience of pleasure, (2) all experiences especially the entire range of valuable mental states, (3) satisfying preferences, (4) satisfying rational preferences.[6]

Once the variety of definitions of human well-being are recognised and, therefore, some of the inherent difficulties in specifying the utilitarian agenda, it is important to ask how a utilitarian resolves conflicts of preference in the context of limited resources. For the utilitarian equal amounts of utility matter equally regardless of whose utility it is. If utilitarian theory is to be adequate it must resolve these *first order moral conflicts*.[7] Utility maximisation is proposed as the standard of moral rightness. One approach using a utilitarian methodology focuses on the aggregation of individual interests and desires. Each person's interests should be given equal consideration. The life of each person matters equally, from the moral point of view, and hence their interests should be given equal consideration. A second approach sees maximising the good as primary. Bringing about valuable states of affairs is

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3 A. MacIntyre, *Whose Justice? Which Rationality?* (Notre Dame, Ind.: University of Notre Dame Press, 1988), 334

4 V. Guroian, *Ethics after Christendom. Toward an Ecclesial Christian Ethic*, (Grand Rapids, Mich.: William B. Eerdmans Publishing, 1994), 39

5 Cf. W. Kymlicka, *Contemporary Political Philosophy*, (Oxford: Clarendon, 1991), 11

6 Kymlicka, *Contemporary...*, 12-18

7 Plant, *Modern...*, 140

what should be intended and individuals are to be counted equally only because that is the way to maximise value.[8]

Utilitarianism has immediate appeal turning as it does to the general sentiment of benevolence and the moral imperative of beneficence in action. It rejects attachment to rules since such attachment is judged (1) *heartless* because it leads to avoidable human misery and (2) *superstitious* since it is contrary to the commonsense idea that it is always rational to choose the course likely to produce the best available result. Utilitarianism in the view of its supporters is scientific in outlook and goals, seeks an objective, impartial and dispassionate account of right action, uses measurement and ranking where possible and provides a method both for coordinating the multiplicity of satisfactions demanded by a modern society and for harmonising personal rationality with social rationality. In this utilitarianism satisfies the deepest moral intuitions of most people.[9]

The implications of utilitarian thinking for health care delivery are significant. Utilitarian approaches favour policies in health care where (1) cheaper therapies are to be preferred to more expensive ones;[10] (2) expensive or scarce therapies are only to be available to the young and those who are likely to lead long and productive lives; (3) in competition for resources, preference should be given to those likely to receive the greatest benefit in terms of improved length and quality of life and to those likely to make the greatest future social contribution; (4) short-term services only are to be provided, with longer term institutional care eliminated as far as possible; (5) healthcare for the aged, terminally ill, chronically sick or incapacitated, the severely handicapped and the permanently unconscious is to be given the lowest priority or eliminated.[11]

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[8] Cf. J. J. C. Smart, "An Outline of a System of Utilitarian Ethics" in *Utilitarianism For and Against*, edited by J. J. C. Smart and B. Williams, (Cambridge: Cambridge University Press, 1975), 3-74; J. J. C. Smart, "Utilitarianism" in *The Encyclopedia of Philosophy*, edited by P. Edwards, Vol. 8. (New York: Collier Macmillan, 1967), 206-12; for an historical view of utilitarianism see J. Plamenatz, *The English Utilitarians*, (Oxford: Basil Blackwell, 1966); for a critical survey see A. Quinton, *Utilitarian Ethics*, (London: Macmillan, 1973); for a critical analysis of utilitarianism see B. Williams, "A Critique of Utilitarianism" in *Utilitarianism For and Against*, edited by J. J. C. Smart and B. Williams, (Cambridge: Cambridge University Press, 1973), 77-150; D. Lyons, *Forms & Limits of Utilitarianism*, (Oxford: Clarendon Press, 1970)

[9] Smart, "An Outline...", in *Utilitarianism...*, 3-74

[10] Prevention is preferred to cure where it is judged to be cheaper.

[11] *Quality-Adjusted-Life-Years* (QALYs) is an example of the application of utilitarian thinking to health care allocation. The quality of life criterion is applied whenever health care is allocated on the basis of expected outcome for the patient only, assessed according to some standard of quality of life or well-being. Preference is given to the patient, treatment policy, institutional arrangement etc. expected to yield the greatest net increase in quality of life within the given

John Rawls, in *A Theory of Justice*, complained that twentieth century political theory was caught between the two extremes of utilitarianism and intuitionism. The latter is an unsatisfactory alternative to utilitarianism since it does not offer an alternative theory that makes sense of one's intuitions.[12] While intuitionism is weak as an account of practical reasoning it has two strengths that were important for Rawls. First, it defines the right independently of the good and so makes rightness a fundamental, irreducibly moral notion. Second, it absorbs the Kantian doctrine of the inviolability and dignity of moral personality, thereby decisively rejecting the utilitarian tendency to view human beings as nothing more than pleasure-containers, to be filled or emptied like a glass of water.[13] Rawls' contractual theory has particular affinities with Kant's moral philosophy. On this account it bears many of the weaknesses of Kant's endeavour to "deduce objective, obligatory ends from the mere analysis of what it is to be a rational moral agent."[14] Wolff's critique is worth quoting in full:

> The heart of Rawls's philosophy is the idea of the bargaining game, by means of which the sterility of Kant's formal reasoning was to be overcome, and a principle was to be established that would combine the strengths and avoid the weaknesses of utilitarianism and intuitionism. The idea is original, powerful, and elegant, but it simply does not stand up. The original sketch of the bargaining game was comprehensible, but it was open to crushing objections. The device of the veil of ignorance enables Rawls at least initally to avoid the pitfalls of the first model while seeming to link his philosophy to that of Kant. But the move is ultimately fatal, for in striving for absolute universality, for a contemplation of the foundations of social philosophy *sub specie aeternitatis*, Rawls abstracts from all that is characteristically human and social. The result is a model of a choice problem that is not sufficiently determined to admit of solution, and neither historical nor human enough to bear a useful relationship to the real issues of social theory.[15]

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budget. Cf. W.T. Reich, "Life. II. Quality of Life" in *Encyclopedia of Bioethics*, edited by W.T. Reich, Vol.2, (New York: The Free Press, 1978), 829-40

12 Rawls describes intuitionist theories as having two features: "first, they consist of a plurality of first principles which may conflict to give contrary directives in particular types of cases; and second, they include no explicit method, no priority rules, for weighing these principles against one another: we are simply to strike a balance by intuition, by what seems to us most nearly right. Or if there are priority rules, these are thought to be more or less trivial and of no substantial assistance in reaching judgement." J. Rawls, *A Theory of Justice*, (Oxford: Oxford University Press, 1973), 35

13 R. P. Wolff, *Understanding Rawls. A Reconstruction and Critique of 'A Theory of Justice'*, (Princeton, N.J.: Princeton University Press, 1977), 12. Wolff notes that Rawls's sympathies and antipathies are equally divided. "Morally, he is clearly more comfortable with the intuitionists than with the utilitarians; but methodologically his heart is with the utilitarians, and with the neo-classical economists who took utilitarianism as the moral foundation of their elegant theoretical constructions." (*ibid.*, 12)

14 Wolff, *Understanding Rawls*, 111

15 Wolff, *Understanding Rawls*, 179

Rawls began to fashion a reply in the light of this critique, admitting that his theory was better understood as a philosophy for modern liberal democratic polities. Throughout Rawls has asserted his intent to develop a Kantian conception of justice, what he describes as "Kantian constructivism". It is constructivist because, in the first place, the focus is on the construction of a fair procedure: if the procedure is fair, the outcome will be fair (i.e. pure procedural justice). The approach is Kantian since Rawls, like Kant, wants to supply justifications for moral principles which are not dependent for their legitimacy on the vagaries of human nature, on human desires, passions or instincts.[16]

A third influence on contemporary political theory is the tradition of the social contract. Historically social contract has been invoked as an explanation or justification of the authority of the state. Common to contract theories is the claim that sovereignty resides originally in individuals. When this is aggregated and transferred to a bearer who exercises authority unanimous agreement of the original sovereignty-holders is required. From the standpoint of moral theory there are two contractarian traditions. The first represented by John Locke assumes a particular moral theory as one of the promises integral to the contract. His understanding of natural rights and the law of nature is assumed on intuitionist grounds. The second contractarian tradition derives from Rousseau. It too begins with a state of nature and a theory of human nature but asserts that entry into civil society by means of a social contract works a moral transformation on the original contractors (from a "private will" to a "general will"). Rawls attempts to go beyond the utilitarian-intuitionist impasse. He invokes a version of the of the social contract theory proposed by Rousseau.[17]

The edifice of the liberal state has been constructed on three foundations: utilitarianism, Kantian rationalism and contract theory. This provides the framework for contemporary discussions of justice.

3.1.2 Justice

The historical and contemporary literature on justice is enormous.[18] It is sufficient in this section simply to sketch two frameworks of political and justice theory to be

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16 C. Kukathas and P. Pettit, *Rawls 'A Theory of Justice' and its Critics*, (Cambridge: Polity Press, 1990), 125

17 Wolff, *Understanding Rawls*, 13-15

18 For an historical and philosophical view see G. Del Vecchio, *Justice. An Historical and Philosophical Essay*, (Edinburgh: Edinburgh University Press, 1952); O.A. Bird, *The Idea of Justice*, (New York: Frederick A. Praeger, 1967). For recent surveys of justice see J. P. Sterba,

studied, compared and contrasted in a variety of ways throughout this thesis. These two frameworks will be taken up in detail in chapters 4 and 5 in the work of Norman Daniels and Daniel Callahan as they analyse the question of justice, health care and the aged. Daniels' thought ""is squarely within the tradition of political liberalism, while Callahan calls on a communitarian political philosophy."[19]

In the Nicomachean Ethics, Aristotle distinguishes justice in the broad sense from its use in a narrower sense.[20] Broadly speaking justice refers to the *whole of virtue*. It is equivalent to what is lawful or morally right. In the narrow sense justice refers to *fairness in distribution*. Here justice concerns itself with the ethically appropriate way to spread limited resources throughout the moral community.[21]

Justice is a quality predicated of persons, choices and complexes of persons and choices that constitute situations and systems. Distributive justice concerns the distribution of benefits and burdens. Justice, therefore, is about relations *between persons*. It assumes some commonality of life and interests and the fact that one's choices affect others. Justice is traditionally defined as *giving to others their due*, respecting their rights and entitlements and discriminating between persons only on the basis of a morally relevant difference. But *due* can be conceived in terms that are narrow or wide. In the prior sense justice is judged as fulfilling obligations arising from a promise, a contract, custom or a social role, whereas justice in the wide sense entails dealing uprightly with others in every respect. Because of this difference in perception of justice, theories of justice differ considerably in the way they specify how people are to be judged equal and unequal, what they are owed and what they owe to each other. This variety of approaches is expressed concretely in bioethical discussions on the distribution of health care.

In contemporary society there are various conceptions of ethics and justice. Alisdair MacIntyre characterises this state of affairs as *competing rationalities* and *rival justices*.[22] Not only do people hold to theories which differ one from another, they also

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"Justice" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 3, (New York: Simon & Schuster Macmillan, 1995), 1308-15; S.I. Benn, "Justice" in *The Encyclopedia of Philosophy*, edited by P. Edwards, Vol.3 (New York: Macmillan and Free Press, 1967), 298-302

[19] D. W. Brock, "Justice, Health Care, and the Elderly", *Philosophy and Public Affairs* 18 (1989): 298

[20] *Nicomachean Ethics*, Book 5; Aristotle, *The Nicomachean Ethics of Aristotle*, translated with an introduction by Sir David Ross, (London: Oxford University Press, 1972), 106-136; for a critical analysis of Aristotle's treatment of justice see W. F. R. Hardie, *Aristotle's Ethical Theory*, (Oxford: Clarendon, 1968), 182-211; D. Ross, *Aristotle*, (London: Methuen & Co, 1971), 209-215

[21] Cf. R. M. Veatch, *A Theory of Medical Ethics*, (New York: Basic Books, 1981), 253-254

[22] MacIntyre, *Whose Justice?*, 1-11

subscribe to incoherent fragments deriving from different traditions of ethics and justice. Thus some will argue that to be rational and just in practice an individual must act on the basis of those constraints which any rational and impartial person agrees should be imposed (e.g. Rawls). Others give priority to seeking one's own ends, whatever they be, provided there is no interference with the rights of others (e.g.Nozick). Others again, focus on calculations that maximise net benefits (e.g. Singer).[23]

3.1.2.1 Two Perspectives

Charles Taylor provides a useful framework for understanding, in general terms, contemporary philosophical discussion of justice.[24] He portrays the literature in terms of an *atomist view* and a *social view*. Both approaches generate different principles of distributive justice. They operate with different notions of the human good and with different views of the way an individual is dependent on society to realise the good.[25]

Taylor locates the origins of the *atomist view* with John Locke. In this approach the human good is perceived as attainable by the individual alone. What people derive from association in realising the good are a set of aids only contingently linked to this association, e.g. protection from attack by others or benefits of higher production. The atomist view of justice invokes a context-less justice of the state of nature and argues for the (partial) preservation in civil society of some of its features. This grounds one of the arguments for inalienable rights. The underlying notion of distributive justice is equality. In the context of justice equality means there should be equal fulfillment. What equality means in society is directly dependent on what are seen to be the aims of the association. Equality is simply the fulfilling of these aims for everyone alike. The atomist view sees the individual not only as a possessor of property but as an independent being with his or her own capacities and goals. The

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23 Five major conceptions of justice dominate late 20th. century philosophy: (1) a libertarian conception, which takes liberty as the ultimate political ideal; (2) a socialist conception which gives priority to equality; (3) a welfare liberal understanding which takes contractual fairness or maximal utility as the priority; (4) a communitarian view which takes the common good as the ultimate political ideal; (5) a feminist perspective which sees a gender-free society as the ultimate political ideal. Sterba, "Justice", in *Encyclopedia of Bioethics*, 1308

24 C. Taylor, "The Nature and Scope of Distributive Justice" in *Justice and Equality. Here and Now*, edited by F. S. Lucash, (Ithaca, N.Y.: Cornell University Press, 1986), 34-67

25 In discussing the relative size of the health care budget vis-a-vis other social goods Outka suggests there are five standard conceptions of social justice operating: (1) to each according to his merit or desert; (2) to each according to his societal contribution; (3) to each according to his contribution in satisfying whatever is freely desired by others in the market place of supply and demand; (4) to each according to this needs; (5) similar treatment for similar cases. The first three are less relevant to health care because health has certain distinctive features. G. Outka, "Social Justice and Equal Access to Health Care", *Journal of Religious Ethics* 2 (1974): 11-32

aims of association are not so much for the protection of property but enable people to join their capacities. This allows each individual to be much more productive than if left alone. The capacities individuals bring to the association are, however, of very unequal value. Thus, on the principle of equal fulfillment of the aims of association, those with especially useful capacities who really use them to the full in collaborating with others, ought to receive a greater share of the resultant product.[26]

This understanding is an implicit background to a widely held principle of distributive justice in contemporary society. Taylor calls this principle the *contribution principle*. It lies behind a widely felt intuition that highly talented people ought to be paid more than the ordinary citizen. Furthermore, the atomist point of view assumes that the individual needs society, democratic institutions, the rule of law, only for the Lockean purpose of protection. Underlying this is the conviction that an individual's self understanding, aspirations and life projects are to be freely chosen. This defines modern individualism.[27]

Against this view there stands a *social view* of the human good. An essential constitutive condition of the search for the human good is bound up with being in society. What a person derives from society is not some aid in realising his or her good but the very possibility of being an agent seeking that good. Whatever form the social view takes society is always perceived as an essential condition for human potentiality. This understanding of social structure defines the kinds of subject to whom distributive justice is due. It is not just that the normative structure is untouchable, but also that it is between persons-within-the-normative-structure that justice must be done. From a social perspective there is a first kind of argument, therefore, which spells out the background against which the principles of distributive justice must operate. There is no comparable notion of background in an atomist view. The nearest thing to it from the atomist perspective is the state of nature, the original predicament of justice between independent beings, where justice is not yet distributive justice.[28] Taylor is conscious that the framework for distribution can also be determined for any given society by the nature of the goods the members of that society seek in common. This can vary historically.[29]

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[26] Taylor, "The Nature ...," in *Justice and Equality*, 52

[27] Taylor, "The Nature ...," in *Justice and Equality*, 59

[28] Taylor, "The Nature ...," in *Justice and Equality*, 38, 40, 42

[29] In this Taylor agrees with the approach of Michael Walzer. Cf. M. Walzer, *Spheres of Justice: A Defence of Pluralism and Equity*, (Oxford: Blackwell, 1983). Walzer has revised and extended his arguments by distinguishing a *thick* type of moral argument which is culturally connected, referentially entangled, detailed and specific from a *thin* argument which is abstract, ad hoc,

3.1.2.2 Rawls and the Communitarian Reaction

Liberal thinkers have viewed liberty and equality as ultimate values for the *polis* and have combined both ideals. This approach has been characterised as contractual fairness or maximal utility. As noted earlier the political writings of Kant provide a conceptual background to this line of thinking. Kant argued that the state ought to be founded on an original contract satisfying the requirements of freedom, equality and independence. The original contract does not have to actually exist. It suffices that the laws of a civil state are such that people would agree to them under conditions in which the requirements of freedom, equality and independence exist. The Kantian ideal of the hypothetical contract as the moral foundation for a welfare liberal conception of justice has been further developed by John Rawls in *A Theory of Justice*. This text has become the classic modern representative of a moderate contractarian egalitarianism. Since its publication it has had an enormous influence on recent Anglo-American political and moral philosophy.[30]

Rawls believes that if a theory of justice is to be accepted logically and practically it must (1) explicate and systematise the commonly held sense of justice in terms of principles which will lead to sound judgments about appropriate social arrangements, (2) achieve a kind of *reflective equilibrium*, or best fit, with the better considered or more confident judgment made by people about what is just in particular situations, (3) eschew any arbitrary ordering or trading-off of morally significant principles or comparisons of pleasures, (4) embody a kind of consensus approach which outlines principles arrived at by procedures all can agree to and which can therefore serve as a public conception of justice in the stable regulation of society, (5) yield principles which are general, universal, public, adjudicatory and final.[31] Rawls' proposal is for *justice as fairness*.

Rawls' general conception of justice consists in one central idea: all social primary goods - liberty and opportunity, income and wealth, and the bases of self-respect - are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favoured.[32]

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detached and general. Thick arguments play a larger role in determining views about domestic justice and shape criticism of local arrangements. Thin arguments shape views about justice in foreign countries and in international society. M. Walzer, *Thick and Thin. Moral Argument at Home and Abroad*, (Notre Dame, Ind.: University of Notre Dame Press, 1994)

30 Sterba, "Justice", in *Encyclopedia of Bioethics*, 1310-1311

31 Rawls, *A Theory of Justice*, 4-5, 18-21, 34-40, 122, 387-388, 517, 580-581, 130-136

32 Rawls, *A Theory of Justice*, 303

In this general conception Rawls ties the idea of justice to an equal opportunity to share social goods. He adds, however, an important twist. People are to be treated as equals by removing not all inequalities, but only those which disadvantage somc. If ccrtain inequalities benefit everyone then they will be acceptable to everyone. Inequalities are allowed if they improve an initially equal share, but are not allowed if they invade one's fair share. Justice is thus viewed as fairness. Rawls articulates his understanding of justice as fairness in two principles. The first principle is: "each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all." The second is: "social and economic inequalities are to be arranged so that they are both: (a) to the greatest benefit of the least advantaged, and (b) attached to offices and positions open to all under conditions of fair equality of opportunity."[33]

By means of the concept of a social contract Rawls gives a procedural interpretation to Kant's notion of autonomous choice as the basis of ethical principles. In the so called *original position* it is proposed that choices are fair because representative persons choose from behind a veil of ignorance. The outcomes of this social contract are the above two principles. They assure equal opportunity and stipulate permissible inequalities which protect or improve the position of the least advantaged (the strategy of the *maximin*). So as not to lock in inequalities of position and power for all time the persons in the original position stipulate (1) a liberal principle of "fair equality of opportunity" and (2) a "just saving principle" since the original players are unsure as to which generation they will belong.

Two priority rules govern the application of these principles of justice as fairness: the first priority rule (the priority of liberty) states that the principles of justice are to be ranked in lexical order and therefore liberty can be restricted only for the sake of liberty.[34] The second priority rule (the priority of justice over efficiency and welfare) states that the second principle of justice is lexically prior to the principle of efficiency and to that of maximising the sum of advantages; and fair opportunity is prior to the difference principle.[35]

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33 Rawls, *A Theory of Justice*, 302-303

34 "There are two cases: (a) a less extensive liberty must strengthen the total system of liberty shared by all; (b) a less than equal liberty must be acceptable to those with the lesser liberty." Rawls, *A Theory of Justice*, 302

35 "There are two cases: (a) an inequality of opportunity must enhance the opportunities of those with the lesser opportunity; (b) an excessive rate of saving must on balance mitigated the burden of those bearing this hardship." Rawls, *A Theory of Justice*, 303

Central to the agenda of welfare liberal justice is an understanding of self-determination. Rawls argues in his account of self-determination that the *neutral state* is a prerequisite of contemporary society. Such a state is one which does not justify its actions on the basis of the intrinsic superiority or inferiority of conceptions of the good life. Furthermore, it does not deliberately attempt to influence people's judgements of the value of these different conceptions.[36] This approach endorses a thin textured notion of the good. Justice is concerned only with the distribution of those primary goods which can be used to advance the many different ways of life chosen by people as their life projects.

Critical analysis of Rawls' approach to justice-as-fairness has provoked him, in more recent times, to restrict the scope of his theory.[37] Justice-as-fairness is now primarily the concern of the *polis*. Refinements in his approach point to some of the flaws critics had detected in *A Theory of Justice*. Three issues are significant in Rawls' rethinking of justice as fairness. First, social unity in a liberal society is "founded on an overlapping consensus, on a political conception of justice."[38] Second, right has priority over ideas of the good. This he specifies as follows:

> First, the priority of right means (in its general meaning) that the ideas of the good used must be political ideas, so that we need not rely on comprehensive conceptions of the good but only on ideas tailored to fit within the political conception. Second, the priority of right means (in its particular meaning) that the principles of justice set limits to permissible ways of life: the claims that citizens make to pursue ends transgressing those limits have no weight. The priority of right gives the principles of justice a strict precedence in citizens' deliberations and limits their freedom to advance certain ways of life. It charactertizes the structure and content of justice as fairness and what it regards as good reasons in deliberation.[39]

Third, "the good reasons in deliberation" demand the notion of *public reason*. Public reason is characteristic of a democratic people. It is the reason of its citizens, of those sharing the status of equal citizenship. The subject of their reason is the good of the public. Public reason, then, is public in three ways: (1) as the reason of citizens as such, it is the reason of the public; (2) its subject is the good of the public and matters

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36 Kymlicka, *Contemporary...*, 205

37 J. Rawls, *Political Liberalism*, (New York: Columbia University Press, 1993). For a critique of Rawls see N. Daniels, ed., *Reading Rawls. Critical Studies on Rawls' 'A Theory of Justice'*, (Oxford: Basil Blackwell, 1975); B. Barry, *The Liberal Theory of Justice. A Critical Examination of the Principal Doctrines in 'A Theory of Justice' by John Rawls*, (Oxford: Clarendon, 1973); B. Barry, *Theories of Justice*, Vol. 1: A Treatise on Social Justice, (Berkeley: University of California Press, 1989), 179-254; Wolff, *Understanding Rawls...*; C. Kukathas P. Pettit, *Rawls 'A Theory of Justice' and its Critics...*

38 Rawls, *Political Liberalism*, 133-172

39 Rawls, *Political Liberalism*, 209

of fundamental justice; and (3) its nature and content are public, given the ideals and principles expressed by society's conception of political justice and conducted open to view on that basis.[40]

Individual liberty, neutrality and a thin textured theory of the good, together with the three specifications made by Rawls more recently, lead to a particular understanding of the *common good.* The common good for Rawls is adjusted to fit the pattern of preferences and conceptions of the good held by individuals. Communitarian thinkers, on the other hand, propose a substantive conception of the good life which defines the community's way of life. This common good, rather than adjusting itself to the pattern of people's preferences, provides a standard by which those preferences are evaluated.[41] Aristotle argued that the human grasp of the cosmic order (*theoria*) is a kind of science in the strong sense of a knowledge of the unchanging and eternal. Practical wisdom (*phronesis*) is a kind of awareness of order, the correct order of the ends of personal life which integrates all of one's goals and desires into a unified whole in which each has its proper weight.[42] Aristotle's attempt to link the universal claims of moral knowledge, of what can be identified by reason and particular circumstances, remains a problem for contemporary political theorists.[43] It is implicit in the tension between the politics of neutrality and the politics of the common good proposed by recent communitarian thinkers.[44]

In the 1980s the so called *communitarians* challenged the asocial individualism they saw implicit in the liberal conceptions of the person, the community and the good. Most often these critics resorted to Aristotle's theory of justice. No attempt has been made to develop a specifically communitarian theory of justice. Communitarian thinkers have primarily reacted to the Rawlsian proposal. In this context it is well to note that an Aristotelian justice framework does not, of itself, commit the user to a particular understanding of justice.[45] On this account communitarianism is an elusive doctrine to define. Some authors, e.g. Sandel, Taylor and Walzer, develop substantial critiques of Rawlsian justice and react to aspects of his liberal political theory. Others, such as MacIntyre, go beyond a critique of Rawls and focus on the notion of

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40 Rawls, *Political Liberalism*, 213

41 Kymlicka, *Contemporary…*, 206-207

42 C. Taylor, *Sources of the Self. The Making of the Modern Identity*, (Cambridge, Mass.: Harvard University Press, 1989), 125

43 Plant, *Modern…*, 37

44 Kymlicka, *Contemporary…*, 206

45 Sterba, "Justice" in *Encyclopedia of Bioethics*, 1312

the good or virtuous person living in a community of character.[46] For the purposes of this thesis communitarians are identified as those who maintain a social view of society and justice as outlined above.

Communitarian thinkers have raised a number of difficulties inherent in Rawlsian and liberal approaches to justice questions. The first pertains to the notion of the human person. Communitarians maintain that liberal approaches view persons distinct from their ends (or values, or conceptions of the good). They do this in a way that ignores how persons actually do relate to those ends.[47] Second, liberalism misunderstands the relation between persons and the society in which they live. The extent to which a society shapes who they are and the values that they have is not considered.[48] Liberalism, in effect, proposes a type of asocial individualism. Third liberal thinkers argue that their conclusions apply universally and cross-culturally. Critics have focused on liberalism's failure to give due weight to cultural particularity, namely the ways in which different cultures embody values, social forms and institutions.[49] Fourth, communitarians reject the moral subjectivism they see underpinning liberal theory.[50] Fifth, the subjectivist position attributed to liberal theory argues that the state should not embody in its political arrangements judgments about which conceptions of the good (perfection) are better than others. Subjectivism, it is claimed, denies that such judgments can be objective and rational. Communitarian thinking, on the other hand, argues that, rather than acting as a neutral arbiter, the liberal state actually smuggles in its own particular understanding as to how people should live, its own ideal as to what constitutes the good life.[51]

3.1.2.3 Distributive Justice

A social perspective of justice considers the principles of distributive justice as well as the framework of such justice. The argument runs along these lines. Although the economic contribution of individuals to a society may be of very unequal value, nevertheless, as members of a community who sustain together certain kinds of relations, of civility or mutual respect or common deliberation, their mutual

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46 Neither strand of communitarian thinkers has yet offered a full affirmative case for another theory to replace what they have attacked. Cf. L. L. Weinreb, *Natural Law and Justice*, (Cambridge, Mass.: Harvard University Press, 1987), 251.

47 S. Mulhall and A. Swift, *Liberals and Communitarians*, (Oxford: Blackwell, 1992), 10

48 Mulhall and Swift, *Liberals and Communitarians*, 13-18

49 M. Walzer in *Spheres of Justice* argues for an appreciation of cultural particularity and how this is central to a proper understanding of the way communities arrange themselves politically

50 Mulhall and Swift, *Liberals and Communitarians*, 21-25

51 Mulhall and Swift, *Liberals and Communitarians*, 32

indebtedness is fully reciprocal, or sufficiently reciprocal so that judgments would be impossible and invidious.[52]

In his discussion of particular and general justice Charles Taylor points out that particular justice is a virtue whose opposite is *pleonaxia*, that is grasping more than one's share. Criteria of distributive justice are thus meant to give the basis for knowing what each person's share is, and hence when an individual is grasping and, therefore, unjust. At this point Taylor recognises that both framework questions and criteria of distribution are derived at least in part from the nature of the association and that of the goods sought in common. Consequently the demands of distributive justice can and will differ across different societies and at different moments in history.[53] There are three main families of views about distibutive justice in contemporary society: (1) the contribution principle; (2) the family of liberal or social democratic views that justify egalitarian distribution; (3) Marxist views which reject the question of distributive justice altogether on the grounds that it is both insoluble and unnecessary in a communist society.[54]

In the light of contemporary concerns for equality in the distribution of benefits and burdens Taylor observes that:

> [i]f we think of the public institutions as just existing to protect liberty, they can consist with almost any degree of inequality, as we can see from Locke's theory. But if we think of these institutions as nourishing the sense of liberty, and in particular through interchange and common deliberation then great inequalities are unacceptable.[55]

If people are engaged together in a society that not only defends liberty but also sustains the sense of liberty, then the two forms of argument of the social perspective become relevant. First, a certain degree of equality is essential if people are to be

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52 Taylor, "The Nature...," in *Justice and Equality*, 44

53 Taylor, "The Nature...," in *Justice and Equality*, 47. Taylor illustrates this with reference to contemporary discussion of distributive justice. He considers two areas to be of current concern: (1) "differentials": the question of allowable differences between wages or income received for different kinds of work; (2) "equalization principles": which cover the gamut of policies that attempt to redistribute income, economic prosperity, life opportunities, either by transfer of payments or by special programs to develop certain regions or to allow certain disfavoured groups to catch up, e.g. opportunity for education.(*ibid.,* 50). Equality is the issue in both areas. The strain arising in western societies is between the drive for equality on the one hand and the sense of justified differentials which the contribution principle yields on the other (*ibid.,* 53). Taylor progresses his thinking in a related area when he explores the tension involving recognition of particular group identities by public institutions. Cf. C. Taylor, "The Politics of Recognition" in *Multiculturalism and 'The Politics of Recognition'*, (Princeton, N.J.: Princeton University Press, 1992), 25-72

54 Taylor, "The Nature...," in *Justice and Equality*, 56

55 Taylor, "The Nature...," in *Justice and Equality*, 60

citizens of the same state. This degree of equality becomes a background feature to which any principle of distributive justice must conform. Second, it can be argued that the balance of the debt all mutually owe as citizens, maintaining together institutions of common deliberation, is much more equal than is that of each person's economic contribution.[56]

Because of this the search for a single set of principles of distributive justice must be abandoned. A modern society can be seen under different, mutually irreducible perspectives and consequently can be judged by independent, mutually irreducible principles of distributive justice. Things are made more complex when one reflects that there is no single answer as to what should be the unit within which people owe each other distributive justice. Even within one model of society there are different degrees of mutual involvement which create different degrees of mutual obligation. Justice must be thought of as between individuals and between communities, and perhaps within communities as well.[57] Because of the privatising features of modern culture atomist illusions continually surface.There is a tendency to forget the ways in which each and everyone depends on society to be a full human agent and also to be capable of the contribution that each makes.[58]

The two frameworks, atomist and social, together with the discussion of the liberal and communitarian notions of justice have been explored with the contributions of Daniel Callahan and Norman Daniels in mind.[59] Daniels develops the contractarian

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56 Taylor, "The Nature...," in *Justice and Equality*, 60

57 "If this all means that there may be no such thing as *the* coherent set of principles of distributive justice for a modern society, we should not be distressed. The same plurality emerges in Aristotle's discussion of justice in Politics III and IV. Those who adopt a single exclusive principle, Aristotle says, 'speak of a part of justice only'(*meros ti tou dikaiou legousi,* 1281a10)." Taylor, "The Nature...," in *Justice and Equality*, 62

58 Taking account of these considerations would require that the contribution principle be combined with three other, more egalitarian ones. (1) Common citizenship requires a certain degree of equality, or put negatively, cannot consist with too great inequalities. (2) The principle of distribution in which our mutual indebtedness is much more equal except insofar as some who make a signal contribution to public life deserve special consideration. (3) However, our contributions are not entirely "ours" since both the forming of our capacities and their worth depend to some extent on society and its modes of production. Taylor, "The Nature...," in *Justice and Equality*, 64

59 This broader framework is necessary to evaluate adequately current discussions of distributive justice. Much of the literature assumes these wider perspectives. Most authors on justice in health care describe justice in utilitarian, contractarian, egalitarian terms. See: E. E. Shelp, "Justice: A Moral Test for Health Care and Health Policy" in *Justice and Health Care*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1981), 213-29; A. Buchanan, "Justice: A Philosophical Review" in *Justice and Health Care*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1981), 3-21.; A. Buchanan, "Health-Care Delivery and Resource Allocation" in *Medical Ethics*, edited by R. M. Veatch, (Boston: Jones and Bartlett, 1989), 293-326; R. M. Veatch, *A Theory of Medical Ethics*, (New

approach of John Rawls and is closer to the atomist view of justice thinking originating with Locke. Callahan's approach is communitarian and operates out of a social view of distributive justice. A detailed analysis must wait until the next chapter.

3.2 BENEFICENCE AND THE RIGHT TO HEALTH CARE

Chapter 3 maps the political, justice and health care landscape within which the contribution of Norman Daniels and Daniel Callahan to the questions of just health care for the elderly must be assessed. This section deals with a number of key ideas that have long been associated with practical care of the neighbour especially in cases of medical necessity. During the last century the notions of *philanthropy* and *altruism* have been progressively removed from debates about health care. The concept of *beneficence* has continued in use in the language of medicine and health care gutted, however, of its traditional meaning. It is my intention here to examine the provenance of all three terms and to reintroduce them into the discussion on health care for the aged. This process is a major element in the originality of this thesis. Because beneficence, philanthropy and altruism have diminished currency in the medicine and health care of the liberal state it is necessary to elaborate their lineage in a little more detail than might be usual in a study such as this. Once this inquiry has been completed it is then possible to consider recent claims that citizens have a right to health care.

3.2.1 Beneficence

Two broad ethical traditions flow through medicine in the West: competence and compassion. The ideal doctor has always been seen as the bearer of both virtues. Any departure from either virtue has been deplored.[60] In an era that emphasises competence and technical proficiency there has been an increasing demand for a greater role to be given to compassion. A plea has been made for *samaritanism* in the practice of medicine. This is understood in secular terms to be the human support function that eases the acceptance of technology and allows it to be applied to temper

York: Basic Books, 1981); T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics*, 3rd ed., (New York: Oxford University Press, 1989), 265-270

60 A. R. Jonsen, *The New Medicine...*, 39-40

the harshness of illness.[61] The parable of the Good Samaritan in the gospel of Luke is the basis of this approach.[62]

The example of the Good Samaritan was used in the first centuries of the Christian era and throughout the medieval period to exemplify the duties of the Christian doctor. Jonsen argues that the *samaritanian principle* emphasising compassion deserves the same status as the *Hippocratic principle* of competence in contemporary medicine.[63] For the Christian tradition acting in a neighbourly way is a concrete expression of Jesus' great commandment of love. The double commandment to love God and neighbour encompasses the totality of moral claims that can be made on a person.[64] The essence of a theological ethic consists in "the thousand-fold specific and concrete formulations of charity, the mother and root of all virtue."[65] Charity is first and foremost *benevolence*, an attitude of mind and heart that wishes the best for one's neighbour. *Beneficence* is directed to doing good. The actual performance of good deeds, however, occurs in history and is subject to limits of knowledge, imagination, time, space, ability, and resources.[66]

Two alterations in the understanding of beneficence must be noted here. First, much contemporary bioethical usage either views beneficence as synonymous with paternalism or is concerned that frequently doctors fail to distinguish between these two notions in the practice of medicine. Because of this it has fallen into disfavour. Second, the theological notion of charity expressed in the notion of beneficence has suffered in recent times because of an emphasis on justice. Charity as beneficence has fallen out of fashion. It came to be associated with the gratuitous liberality of the powerful, whereas justice focuses on the claims of the weak and oppressed. The eclipse of the notion of love or charity as the basis of beneficent behaviour began with the work of 17th and 18th century British philosophers. Thomas Hobbes (1588-

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61 Cf. Jonsen, *The New Medicine...*, 38

62 Lk.10:29-37 For an analysis of the parable see P. Perkins, *Love Commands in the New Testament*, (New York: Paulist, 1982), 59-65; V. P. Furnish, *The Love Command in the New Testament*, (London: S.C.M., 1973), 34-45; for detailed exegesis of the parable see J. A. Fitzmeyer, *The Anchor Bible. The Gospel According to Luke (x-xxiv). Introduction, Translation, and Notes*. Vol. 28A, (Garden City, N.Y.: Doubleday, 1985), 882-890

63 Jonsen, *The New Medicine...*, 39

64 The manner of reasoning that serves to clarify this double commandment must be seen, in all cases, as fundamental. Cf. B. Schuller, "Typen ethischer Argumentation in der katholischen Moraltheologie", *Theologie und Philosophie* 4 (1970): 527

65 "la formulation, concretisée, 'specifiée' de mille manières, de la charité 'mère et racine des vertus'." R. Carpentier: "Vers une morale de la charité", *Gregorianum*, 34 (1953): 54

66 J. W. Glaser, *Three Realms of Ethics. Individual, Institutional, Societal. Theoretical Model and Case Studies*, (Kansas City, Mo.: Sheed & Ward, 1994), 4

1679) proposed a determinist philosophy that denied any capacity for choice based on values. At the same time his thinking was relativist denying any independent reference for the terms good and evil.[67] Shaftesbury (1621-1683) and Hutcheson (1694-1746) endeavoured to redress the imbalance created by Hobbes's egoistic interpretation of human nature. Both philosophers insisted on the social dimension of the human and on the naturalness of altruism. Whereas Shaftesbury saw the essence of virtue in a harmony of the self-regarding with altruistic affections, Hutcheson tended to identify virtue with benevolence.[68] David Hume (1711-1776) conceived of benevolence as one of the instincts originally implanted in human nature. Like Joseph Butler (1692-1752), Hutcheson and Adam Smith (1723-1790) and other thinkers of the period Hume was less concerned with ethical problem solving as with describing the role and place of benevolence in the moral landscape of human life. Adam Smith while using the term beneficence restricted it to the virtue of goodwill viewing it as a moral passion rather than a principle.[69] Smith's moral theory gave a central place to *sympathy*. While Hutcheson and Hume frequently employed this notion for Smith the "sentiment of sympathy is not confined to the virtuous and the humane; it is found in all men to some degree."[70] In Hume's writings self-interest is the original motive establishing justice. The human capacity for sympathy is the source of the moral approval given to the virtue of justice.[71] This evolution in 18th century philosophical reflection placed justice at centre stage. It became the criterion for human behaviour in subsequent Anglo-American philosophy.

The process of separating beneficence from its theological roots and the long tradition of Christian thinking about charity and its role in human behaviour has generated particular difficulties for a contemporary appreciation of beneficence. Absence of a suitable and necessary framework for weighing the competing and conflicting demands entailed in doing good will become obvious in the discussion that follows. Furthermore, duties to do good or avoid harm in the health care setting suggest limits and inadequacies in the notion of beneficence. This section of the thesis explores the ethical debate about the nature and scope of beneficence with an eye to the obligation to care for the elderly that arises from justice. The investigation develops in three stages. First, by exploring the evolution of *philanthropia* it is

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[67] L. R. Churchill, "Beneficence" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 1, (New York: Simon & Schuster Macmillan, 1995), 243

[68] F. Copleston, *A History of Philosophy*, Vol. 5, Hobbes to Hume, (London: Burns and Oates, 1961), 184

[69] Churchill, "Beneficence" in *Encyclopedia of Bioethics*, 243

[70] Copleston, *A History of Philosophy*, 356

[71] Copleston, *A History of Philosophy*, 336-337

possible to understand the dominant role beneficence has played as one of the principles of contemporary American medicine and bioethics. Second, an appreciation of *philanthropia* opens up its connection with altruism. Third, philanthropic medicine has been criticised for overlooking the reciprocal influences of individuals and society on the practice of medicine. This is epitomised by current preoccupations with codes and contracts and their place in health care delivery.

3.2.2 Philanthropy

The notion of the *artisan* is fundamental to an understanding of medical philanthropy in the ancient world. As Edelstein observes:

> the artisan has fulfilled his duty if he is intent primarily upon the aim of his art - that is, in the case of medicine, upon restoring health to the body - and thinks of his income afterwards. No other obligations are incumbent upon him, no other personal qualities are demanded of him. It is also clear that in the society of the fifth and fourth centuries [B.C.in Greece], medicine is a craft like all the others and in no way differentiated from them.[72]

The classical age in Greece did not know the concept *profession* but placed the doctor among craftsmen (*technitai*) whose manual labour was judged by the standard of expertness and performance.[73] In the oath attributed to Hippocrates medicine was viewed as a craft, an art, a *tekne*, or to use Alisdair MacIntyre's term, a *practice* - not simply a set of technical skills. "The goal of medicine, the good which is intrinsic to the practice, is identified by the oath as 'the benefit of the sick'."[74] An understanding of *physis* was basic for ancient Greek medicine and for all technical knowledge. Viewing medicine as *techne iatrike* focused its method of knowing. The first rule in

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72 L. Edelstein, "From 'The Professional Ethics of the Greek Physician'" in *Ethics in Medicine: Historical Perspectives and Contemporary Concerns*, edited by S. J. Reiser et al., (Cambridge, Mass.: The MIT Press, 1977), 41

73 Edelstein, "From "The Professional Ethics...," in *Ethics in Medicine*, 48, note 11

74 A. Verhey, "The Doctor's Oath - and a Christian Swearing It" in *On Moral Medicine. Theological Perspectives in Medical Ethics*, edited by S. E. Lammers and A. Verhey, (Grand Rapids, Mich.: William B. Eerdmans Publishing Co, 1987), 74. This is a hard lesson in today's world "in a culture as bullish on technology and as pluralistic in values as our own. There is a constant tendency to reduce medicine to a mere - but awesome - collection of techniques that may be made to serve extrinsic goods, themselves often reduced to matters of taste."(*ibid.*,75) This notion of medicine as a practice contradicts current literature on the professions which are seen as skills learned by training and made accessible to consumers. (*ibid.*,76)

the practice of medicine is an attentive sensory examination of the patient's body as a result of which defects and errors would be gradually corrected.[75]

It has been suggested that the Hippocratic oath functioned as a performative declaration not a descriptive one. It did not just describe reality, it altered it.[76] At the same time it called attention to the importance of the doctor's identity, character and integrity. "The oath expressed and evoked an identity, but it was an identity which recognized its dependence upon and indebtedness to a community and the transcendent."[77] This differs greatly from contemporary understandings which view medicine as a collection of skills and techniques to be used for extrinsic goods. Medicine thus deals with matters of taste not issues of taste. The oath directs attention to the institutions, communities, and traditions within which the doctor's identity is nurtured. It expresses a natural piety permeated with a sense of gratitude, dependence, tragedy and responsibility to the transcendent.[78]

The term *philanthropia* in Greek thought generally indicated good citizenship and democratic, humanitarian inclinations.[79] The element of reciprocity was to be found in the private and public philanthropy of the Greek and Roman worlds. Because of "the *quid-pro-quo* basis of the philanthropy, pity was rigidly excluded as an improper motive; giving motivated by pity would have been resented, for the receiver would be unable to reciprocate."[80]

Galen (c.130-200 A.D.) differed from the teaching of the the pseudo-Hippocratic treatises current in his day. For him the word *philanthropia* came to express a comprehensive love of mankind, a common feeling of humanity. A Stoic emphasis on human brotherhood seems to have influenced use of *philanthropia*. In the Roman Empire it came to denote humane and civilized feeling towards humanity. This is the

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75 P. L. Entralgo, "Professional-Patient Relationship. I. Historical Perspectives" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 4, (New York: Simon & Schuster Macmillan, 1995), 2077

76 Verhey argues that the oath was directed to the reform of the practice of medicine in ancient Greece. Cf. Verhey, "The Doctor's Oath...," in *On Moral Medicine*, 73-74

77 Verhey, "The Doctor's Oath...," in *On Moral Medicine*, 77

78 "Such a natural piety can still nourish and sustain the physician's calling. Its responsiveness to the transcendent can protect the physician both from the presumption of 'playing God' and from the reductionism of plying the trade for hire. It remains part of the fuller vision of medicine." Verhey, "The Doctor's Oath...," in *On Moral Medicine*, 79

79 M. Curti, "Philanthropy" in *Dictionary of the History of Ideas. Studies of Selected Pivotal Ideas*, edited by P. P. Wiener, (New York: Charles Scribner's Sons, 1973), 487

80 D. W. Amundsen and G. B. Ferngren, "Philanthropy in Medicine: Some Historical Perspectives" in *Beneficence and Health Care*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1982), 6

sense in which Galen appears to have used the term.[81] While there is no exact equivalent of *philanthropia* in Latin the word *humanitas* came to have many of the same associations. *Humanitas* comprehends the human virtues that we expect of an educated person: politeness, tolerance, command of the social graces. Included also were notions of kindliness, mercy and consideration of others. *Humanitas*, however, was limited to a narrow circle of urban and educated aristocrats. The word reflected qualities expected of the Roman ruling class. For Galen the good physician must also be a philosopher. In the writings of the Roman physician Scribonius Lagus (d. 50 A.D.) *philanthropia* assumed a narrower and deeper meaning emphasising the dimension of compassion. In this context the doctor must be competent and, at the same time, motivated by compassion and humaneness. He must be a lover of mankind in the sense that *philanthropia* and *humanitas* were popularly used in his time.

The New Testament used *philanthropia* infrequently. Early Christian literature adopted the language of *agape*. This latter notion differed markedly in its use from the *philanthropia* of the Roman world. For the Christian *agape* was grounded in the nature of God.[82] *Agape* is unlimited, freely given, sacrificial (because of God's love revealed in the Incarnation), not dependent on the character of its object. *Agape* is an active principle of love of God requiring love of humans.[83] In fact membership of the kingdom depends on active love.[84] Where there is no love for the neighbour there is no love of God.[85] Jesus' disciples are to be known for their love of one another.[86]

By the end of the second century, however, *philanthropia* began to appear in the Christian vocabulary and by the fourth century it became synonymous with *agape*, especially in the liturgies of the Greek speaking Church of the East. The developing usage of *philanthropia* in the early Christian era points to a tension between the secular medicine of the Greek and Roman worlds and the theology of the Church on the one hand, and between the cure of the soul and the cure of the body on the other. This has been portrayed in terms of a "tension, between those who see medicine as an aspect of God's common grace and physicians as instruments of God, and those who hold that medicine is unnecessary since healing comes by faith and special

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81 Amundsen and Ferngren, "Philanthropy...," in *Beneficence...*, 8-9

82 God is love (1 Jn.4:8)

83 Mt.22:36-40

84 Mt.25:31-46

85 1 Jn.4:20-21

86 Jn.13:34-35

grace."[87] In Christian writings, apart from Luke "the beloved physician"[88], no specific reference is to be found to a Christian physician before the mid-second century. This fact needs to be understood in the light of three practices in early Christianity: (1) the anointing of the sick with oil,[89] (2) the use of relics especially those of martyrs and holy people, and (3) the service of the poor and sick.[90] The healing relationship in the Christian community differed greatly to that of the Hippocratic medicine current at the time. Following the example of the Good Samaritan no natural limits were placed on the type of care to be offered to the sick person. Such care offered to the sick was given by equals and offered free of charge.[91] The establishment of hospitals, orphanages, houses for the poor and aged in the Christian Church can be traced back to the hospital established by Basil the Great (c.372 A.D.). Hospitals (*xenodochia*) patterned after Basil's institution spread throughout the Eastern Church. Monasteries in the West, shaped by the Rule of St. Benedict, maintained this healing work up until the medieval period when urban centres replaced them in importance.[92] It has been observed:

> that Christianity introduced 'the most revolutionary and decisive change in the attitude of society toward the sick. Christianity came into the world as the religion of healing, as the joyful Gospel of the Redeemer and of Redemption. It addressed itself to the disinherited, to the sick and afflicted, and promised them healing, a restoration both spiritual and physical. It became the duty of the Christian to attend to the sick and poor of the community . . . The social position of the sick man thus became fundamentally different from what it had been before. He assumed a preferential position which has been his ever since.[93]

This was possible since the theology of *agape* emphasised the *incarnate* dimension of God's love in the human realm.[94] Both the sick person and his or her carer embody the presence of Christ in the relationship. The *incarnational* dimension, in the Christian view, understands both the sick person and the doctor or carer to be both

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87 Amundsen and Ferngren, "Philanthropy...," in *Beneficence...*, 13

88 Col.4:14

89 Jas.5:14-15

90 Jas.1:27; Mt.25:35-6

91 Entralgo, "Professional-Patient...," in *Encyclopedia of Bioethics*, 2078

92 From just before 12th. cent. there appeared writings of secular doctors and the development of licensure requirements to practice. About the same time moralists attempted to define the moral responsibilities of doctors. The role of monasteries as centres of healing became less important in this period primarily because they were frequently in the countryside and distant from urban populations.

93 Amundsen and Ferngren, "Philanthropy...," in *Beneficence...*, 16 quoting Henry Sigerist.

94 *Incarnation* (Latin: *in carne*) literally means *in the flesh*. This central doctrine of Christianity asserts that God has come among us *in a fleshly way* in the person of Jesus and that Christ continues to live *enfleshed* in the lives and activity of believers through the power of the Holy Spirit.

recipient and giver in the doctor-patient or carer-patient dyad. This provides a much fuller understanding than is to be found in the notion of *philanthropia* which concentrates primarily on the virtues of the care-giver or doctor in the relationship. A consequence of this emphasis on the philanthropic ethic is a neglect of the virtues to be practised by the patient.[95]

3.2.3 Altruism

Altruism, understood "as spontaneous and undemanded devotion to other persons' interests and welfare"[96], is closely linked with the traditional understanding of philanthropy. In the modern world a number of forces appear to be weakening the priority health care has long given to altruism. Four of these are significant: (1) the increasing pace of medical practice; (2) the concentration of care in larger and less personal institutions; (3) growing commercialisation of medical services; (4) increasing technologising of medicine. In addition there is an "increasingly prevalent belief that health care should not be thought of as something freely given by one generous group of persons to others in need, but rather of health care providers."[97]

How can altruism which is at the heart of philanthropy be preserved in today's health care environment? Green has focused on two aspects of contemporary medical care that symbolise the practice of altruism. First is the process which reduces the *tyranny of the gift*. Using Titmuss's analysis of the American and British systems of blood collection he observes that:

> anonymity functions as a guarantee of the relative purity of the altruism that lies behind these systems of care, a testimony to the truly spontaneous expressions of social feeling they represent. The anonymity of recipients carries compassion beyond the socially limited sphere of one's immediate family and friends to society as a whole. And the fact that the distant recipents of one's compassion are unable to reward these acts or personally to express their gratitude frees altruism from any hint, however subtle, of selfishness, coercion or control.[98]

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95 Two authors have sought to redress this imbalance. Karen Lebacqz proposes the two cardinal virtues of fortitude or courage in the face of fear together with prudence, or acting in accord with the real. She adds the theological virtue of hope (i.e. trust in the attainment of ends). W.F. May in discussing the virtues of the elderly suggests that they need to exercise *memoria* (learning from the past), *docilitas* (the capacity to be silent and thus to perceive), *solertia* (a readiness for the unexpected and an openness to the future), *hilaritas* (a virtue related to wisdom). In addition he also points to the virtues of humility, benignity and integrity for the aged when they are ill and are recipients of care.

96 R. M. Green, "Altruism in Health Care" in *Beneficence and Health Care*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1982), 239

97 Green, "Altruism…," in *Beneficence…*, 241

98 Green, "Altruism…," in *Beneficence…*, 244-245

This provision is ideally held to be impersonal, a commitment to *unnamed strangers*. Laws, social institutions or procedures mediate the separation of those motivated to help from those who will be recipients of their generosity and concern. From this point of view medical altruism rests on something of a paradox: intense social feeling and interpersonal concern is channeled through impersonal institutions[99]:

> [T]he stimulus behind many modern social welfare programs, not just those in health care, is an older kind of altruism combined with a contemporary moral sense that there should be, as one writer puts it, 'a degree of social distance between helped and helper'. Concepts of justice and rights partly express and protect this necessary distance. But if this is so, appeals for a 'right' to health care and systems founded on that right display much of the same paradox as that found in Titmuss's work: a deliberately impersonal series of ideas and arrangements is made the vehicle of deep personal concerns.[100]

The second reappraisal of altruism in health care, according to Green, arises from the way economists view collective programs of health care as a form of self-protective sickness insurance. In this approach individuals make provision for their own future health care needs. Establishing a right to health care will effectively endanger altruistic behaviour in the medical setting. For example, recipients of social security payments will receive priority over taxpayers in access to public hospital care. Health care will become increasingly contractual. The compassionate doctor will be transformed into an impersonal agent of society.[101] Volunteerism will be seen to decrease in areas such as research on human subjects and organ transplantation.[102]

Green's analysis is open to criticism since he appears to offer a distinctive reading of Titmuss's work. The latter's study of British and American blood donation systems did not concentrate on the question of anonymity but but on an understanding of the gift and the social value of gift-giving in a society. In accepting the overall framework of the National Health Scheme in the U.K. Titmuss presupposed that this health care framework makes it possible for people to freely give what is most precious, for the common good. The solidarity and sociability involved represent a particular understanding of social or civic personhood. Green's analysis provides an excellent example of an author who reads the British health care scene through spectacles tinted by American preoccupations. The political, social and health care framework within which Green operates mirrors the liberal egalitarianism and rights based contractual understanding of health care in a society of self-interested

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[99] Green, "Altruism...," in *Beneficence...*, 245

[100] Green, "Altruism...," in *Beneficence...*, 246

[101] Green, "Altruism...," in *Beneficence...*, 246-248

[102] Green, "Altruism...," in *Beneficence...*, 249-251

individuals. A misreading such as this is a cautionary tale as the concerns of just health care for the elderly are unravelled in the following chapter. It makes plain that any insights gained from European or American contexts must not be transferred uncritically to the the Australian situation.

3.2.4 Code, Contract and Covenant

William F. May and James Childress are sharply critical of current preoccupations with codes and contracts in modern health care. They draw attention to the fact that obligations in this area derive from obligations founded on reciprocity rather than on a deontology that arises from the profession's own definition of its role-specific duties. Medical codes, in the tradition of Hippocratic philanthropy, ignore responsiveness for gifts or services received:

> The ideal of service, in my judgment, succumbs to what might be called the conceit of philanthropy when it is assumed that the professional's commitment to his fellow man is gratuitous, rather than a responsive or reciprocal, act flowing from his altered state of being. Statements of medical ethics that obscure the doctor's prior indebtedness to the community are tainted with the odor of condescension. [103]

Codes of medical ethics tend to view the professional as independent and self-sufficient when in fact, in the contemporary world, he or she is greatly indebted to the society (for education and privileges) and to patients, past and present (for research and practice). If this indebtedness were recognised the medical profession's duty of beneficence might be grounded in reciprocal giving and receiving rather than in a unilateral view of beneficence as at present. This has implications for the right to health care:

> If beneficence is located in a covenant of receiving and giving, if it is a matter of response as well as of initiative, the physician's attitude may and should be significantly different than in philanthropy. This perspective should loosen the professional's grip on the definition of the content of beneficence, that is, on the benefits sought for the patient.[104]

May has sought to replace codes and contracts with the notion of a *covenant.* A covenant, as opposed to a code, has its roots in specific historical events. Covenant ethics is responsive in character and includes a number of elements. It is grounded in an experience of gift-giving by one partner in the covenant to the other. Central to

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[103] W. F. May, "Code and Covenant or Philanthropy and Contract?" in *Ethics in Medicine: Historical Perspectives and Contemporary Concerns*, edited by S. J. Reiser, A. J. Dyck, and W. J. Curran, (Cambridge, Mass.: The MIT Press, 1985), 70

[104] J. F. Childress, "Duties to Benefit Others" in *Who Should Decide? Paternalism in Health Care*, (New York: Oxford University Press, 1982), 43

this exchange is the promise made when the covenant was entered into. The promise points to future undertakings and events stipulated as part of the covenant. This has the effect of profoundly changing the participants in the covenant.[105] A covenant, therefore, imposes change on all moments of the relationship. This differs considerably from a contract which operates for a limited period of time.

The doctor is greatly indebted to the community for his or her education and for payment. Should the doctor-patient relationship be reduced to a commercial contract a number of defects would become obvious for a contract (1) suppresses the element of gift in human relationships; (2) reduces the relationship to what is minimal; (3) needs which are unpredictable are unable to be exhaustively specified in advance for each patient; (4) knowledge is unequal between patient and doctor; (5) health crises frequently prohibit a consumer to shop around among various vendors as in the commercial world; (6) adherence to a contract may mean the waiving of certain rights the patient is due in justice.[106]

A covenant understanding of the doctor-patient relationship shies back from the idealist assumption that professional action is and ought to be wholly gratuitous, on the one hand, and from the contractualist assumption that it be carefully governed by self-interest in every exchange on the other.[107] Every model of the doctor-patient relationship establishes not only a certain image of the doctor but also a specific understanding of what it means to be a patient. The patient is not merely a passive object like putty in the hands of the doctor but must bring a *will-to-live* and a *will-to-health* to the healing partnership.

The central place of philanthropy in medical ethics from the time of the Hippocratic Code indicates an effort in each age to emphasise caring behaviour toward the sick. The impact of Christianity has been revolutionary. In spite of current pressures diminishing the place of altruism and philanthropy in contemporary health care it is fair to say that the behaviour of doctors to their patients has always required that these virtues be present in the relationship.

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[105] The covenant on Sinai that God entered into with the Hebrews exemplifies the significance and transforming power of a covenant. Cf. G. E. Mendenhall and G. A. Herion, "Covenant" in *The Anchor Bible Dictionary*, edited by D. N. Freedman, Vol. 1, (New York: Doubleday, 1992), 1179-1202

[106] May, "Code ...," in *Ethics in Medicine*, 72-73

[107] May, "Code...," in *Ethics in Medicine*, 74

3.2.5 The Right to Health Care

There was little interest in a right *to* health care until it became clear that modern medicine could save lives, improve their quality and reduce insecurity regarding personal health.[108] Most of the philosophical writing on the right to health care appeared in the 1970s after decisive legislative developments in the area of welfare rights during the mid-1960s.[109] Complementing these welfare rights is an increasingly important health care sector. Four major systems of health care have evolved throughout the world. A total *laissez-faire* approach to health care is to be found at one end of the spectrum, a socialist system at the other. Two variants of a liberal approach stand between. A liberal humanitarian version offers a decent minimum of health care achieved through minimum coercion (taxation) and provides a *safety net* for the poor and the needy. The liberal egalitarian model is best exemplified by the National Health Scheme in the U.K. and the Medicare system in Australia.[110] Equality in health care distribution is a high priority although professionals and patients are free to go outside the public system. Both models of health care value equal access and a decent minimum of health care yet both preserve incentives for individual patients and health care providers.

Foundational to any discussion of health care is the question why health care should be a social responsibility and not simply a matter of individual, voluntary initiative. A host of other questions relating to entitlements, the objects of entitlements, and the distribution of the burdens created by such rights flow from this.[111] Taken together these questions raise some of the most basic issues of personal responsibility, the role of political society and the requirements for equity and justice in the distribution of essential social goods. It is sufficient here to note simply that five approaches are much discussed in contemporary political theory and medical ethics[112]: (1) libertarian theories of thinkers such as H.T. Engelhardt and C. Fried; (2) egalitarian theories of bioethicists such as R. Veatch and J. Childress; (3) egalitarian-libertarian theories such as that of J. Rawls; (4) utilitarian thinking as proposed by philosophers such as P. Singer; and (5) communitarians recognise and affirm what is common among

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108 J. F. Childress, "Health Care, Right to" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM, 1986), 262. Note the right *to* health care which is the focus of our attention in this section is different from rights *in* health care.

109 J. Boyle, "The Developing Consensus on the Right to Health Care" in *Justice and Health Care*, edited by M. J. Kelly, (St. Louis: Catholic Health Association of the U.S., 1984), 75

110 Cf. A. Gutman, *Liberal Equality*, (Cambridge: Cambridge University Press, 1980), 98-101

111 Boyle, "The Developing...," in *Justice and Health Care*, 76-77

112 Cf. J. F. Drane, "Justice Issues in Health Care Delivery", *Bulletin of the Pan American Health Organization* 24:4 (1990): 566-78

persons living in society. They seek to express human sociality as a positive basis for action rather than as a confinement. The will to respect vulnerability in all equally through equity of care is proposed, by this group of thinkers, as the foundation of community in terms of health care. Equitable recognition of needs is a prerequisite for community and equitable care for those needs is its goal. This raises a basic question of social justice in the area of health care. How willing are we to care for the needs of strangers?[113] Contemporary bioethicists have explored this issue in terms of equal access to health care. Gene Outka in an influential study has proposed that:

> [i]llness is the proper ground for the *receipt* of medical care. However, the *distribution* of medical care in less-than-optimal circumstances requires us to face the collisions. I would argue that in such circumstances the formula of similar treatment for similar cases may be construed so as to guide actual choices in the way most compatible with the goal of equal access. The formula's allowance of no positive treatment whatever may justify exclusion of entire cases from a priority list. Yet is forbids doing so for irrelevant or arbitrary reasons.[114]

Critics of Outka's equal access proposal fault it since it implies too much (to each the same thing) and yet at the same time infers too little. In fact as a principle of distribution equal access does not necessarily imply any level of societal allocation of goods. Another area of concern with Outka's approach arises from his focus on *health crises*. Central to his argument is the belief that health crises are for the most part randomly distributed, unpredictable, and undeserved:

> His interpretation of *undeserved* presupposes the other two features: health needs are undeserved largely because they are randomly distributed and unpredictable. Because health needs are undeserved, Outka concludes that standards of justice other than needs are *unfair as well as unkind* in the distribution of health care.[115]

Two further notions have emerged as a result of the debate about the grounds for equal access to publicly provided health care: the place of *rights* where health and health care are concerned and the nature of *needs*.

When considering rights it is important to recognise that a right refers not only to the individual claiming the right it also refers to the obligation incumbent on others

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113 L. R. Churchill, *Rationing Health Care in America: Perceptions and Principles of Justice*, (Notre Dame, Ind.: University of Notre Dame Press, 1987), 100-101

114 Outka, "Social Justice...," 24. Outka arrives at this conclusion after having analysed five conceptions of social justice: (1) to each according to his merit or desert; (2) to each according to his societal contribution; (3) to each according to his contribution in satisfying whatever is freely desired by others in the open marketplace of supply and demand; (4) to each according to his needs; (5) similar treatment for similar cases.

115 J. F. Childress, "Love and Justice in Christian Biomedical Ethics" in *Theology and Bioethics. Exploring the Foundations and Frontiers*, edited by E. E. Shelp, (Dordrecht: Reidel, 1985), 237-238

toward the individual claiming the right. A right is usually asserted as a strong moral justification for possessing, doing, or receiving something of considerable importance in human life.[116] Since the time of Kant rights have been primarily understood as affirming personal autonomy and safeguarding it from interference by authority. The greatly expanded notion of *human rights* further emphasises the place of personal autonomy. Human *needs* have now taken an increasingly important role as a buttress for human autonomy. After all autonomy can be realised only under certain social and material conditions. This shift from *autonomy* to *need* as the basis of certain rights has necessitated a reformulation of the arguments used historically in support of natural, civil and political rights. A resulting complexity has been introduced into rights theory through a consideration of the features of human need. The concept of need is a particularly difficult one to grasp for (1) need is an elastic term; (2) needs may be capricious, transient, trivial, highly idiosyncratic; (3) a need does not generate the right to its satisfaction; (4) needs may be satisfied by material goods and services which may be plentiful, adequate, scarce or nonexistent; (5) it is strange to claim a right to the plentiful or to the nonexistent, while claims on the adequate or scarce seem inevitably to collapse into arguments over priorities of need; (6) the aggregate of personal needs may require satisfaction that would be socially inefficient or even damaging; (7) material goods and services are produced by persons who themselves make claims to their own products and their allocation.[117]

In addition to the various difficulties associated with needs contradictory positions about the social obligation to acknowledge the right to health care are to be found in the literature. Utilitarians argue that society, as a collective agent, has a duty to perform particular acts such as the provision of health care. The argument grounding

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[116] C. Wellman, "Rights. I. Systematic Analysis" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 4, (New York: Simon & Schuster Macmillan, 1995), 2305-10. A standard interpretation of the correlativity thesis argues that obligations establishing someone is owed or entitled to something necessarily have correlative rights, whereas obligations that fail to establish an entitlement do not have correlative rights. In this context two senses of an obligation must be noted: (1) an obligation that is universalizable or a general moral obligation expresses what is owed, whereas (2) this is not the case when the obligation arises from some self-imposed or contingent stricture such as a rule of conscience or a commitment to charity. Cf. T. L. Beauchamp, "The Right to Health Care in a Capitalist Democracy." In *Rights to Health Care*, edited by T. J. Bole and W. B. Bondeson, (Dordrecht: Kluwer Academic Publishers, 1991), 59-60

[117] A. Jonsen, "Health Care III. Right to Health-Care Services" in *Encyclopedia of Bioethics*, edited by W. T. Reich, (New York: Macmillan, 1978), 626. Len Doyal and Ian Gough observe that, in recent times, the concept of needs has been relativised virtually out of existence. If there are no objective needs all that remains are preferences. Social policy is impossible on the basis of preferences. They attempt to develop a coherent theory of need in terms of physical health, autonomy and basic needs of persons. L. Doyal and I. Gough, *A Theory of Human Need*, (London: Macmillan, 1991)

this social obligation is two-fold: the first arises from the need for collective protection, investment and return, the second is demanded by fair opportunity. Essentially "a denial of access to those desparately in need is unjust because needs for health care - unlike, for example, government subsidized recreation in the national parks - can have a direct and profound effect on opportunity, quality of life, and functional capacity."[118]

Proponents of a natural law understanding of human rights and the common good argue that the obligation to help others in need exists even prior to any social mechanisms for facilitating that assistance.[119] The obligation becomes a social duty when the means for providing assistance becomes part of the common good of the community in which one participates. Instrumentalities such as health care should be part of the common good of a community when it is recognised that social cooperation can protect and promote basic concerns of decent human living better than can purely private and voluntary initiatives. These instrumentalities become part of the common good of a society when the society recognises and facilitates their operation.[120] This social obligation is real even when not acknowledged or enforced by government. Furthermore, individual citizens have the primary obligation to provide and pay for the services needed to honour the right to health care, helped as needed by the subsidiary function of government. This approach implies that the right to health care does not necessitate the state to provide health care services or even the primary source of payment for everyone's health care. While need is an appropriate criterion for health care:

> the limits to the health care services to which people are entitled are basically those set by the capability of individuals and societies to provide those services. This limitation on capability is largely moral: the

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118 Beauchamp, "The Right...," in *Rights to Health Care*, 68

119 "Human beings recognize that certain basic goods or values are worthy of their allegiance and that the pursuit of these goods constitute human flourishing. Life and health, friendship and peace, truth and beauty are some of these. We also recognize that these goods are the object not only of individual pursuit but are the goals of our common activity. The obligation placed on us by these goods is not only individual but also common. The community of men - like individuals - ought to pursue and respect these values. The community 'respects' these values in much the same way as individuals do. A community should not act against these values as they are realized in the lives of its members and other people and communities, nor should it allow individuals within the community to do so. Thus, we have the foundation of such negative rights as the right to life, the right to religious expression, and so on." J. M. Boyle, "The Concept of Health and the Right to Health Care", *Social Thought* 3 (1977): 5-17. For a similar approach see G. Grisez and R. Shaw, *Beyond the New Morality: The Responsibilities of Freedom*, (Notre Dame: University of Notre Dame Press, 1974), 11-13

120 J. M. Boyle, "The Right to Health Care and Its Limits" in *Scarce Medical Resources and Justice*, edited by D. G. McCarthy, (St.Louis: The Pope John Center, 1987), 19

> reasonable demands of other social and personal concerns, and the limitations of providing health care equitable for all.[121]

Even when a right to health care is acknowledged implementation of health care programs will differ greatly from nation to nation. Quality of care, access to care and the cost of care together with the various levels of health care in a society are variables affecting the right to heath care. In spite of this it is still possible to say that the right to health or medical care is a moral, general, and conditional right.[122]

The right at issue in American bioethical literature is not the right to *health*, but rather the right to *health care*.[123] As with the reading of Green on altruism outlined earlier, caution must be exercised in assessing the American discussion of the right to health care. Preoccupation with the right to health care has been a peculiarly American phenomenon. For an aging population, however, whether there is a right to *health* merits consideration. Raising this question pushes the issue to a more basic level, to an egalitarian concern for the social conditions that assure the general health of the population. American bioethical literature has framed the issue more narrowly in terms of a right to *health care*. Now that people are old, what is society going to do about it? It follows from this that the link between *equality* and a *right* should be clarified primarily because health care is a complex reality and human needs are capricious. A society may or may not choose to guarantee everyone equality of access to health care. It will, some claim, never be able to guarantee equality of health to all.[124] Nevertheless, if the concern is about the right to *health* a society may

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[121] Boyle, "The Right...," in *Scarce Medical...*, 24; Albert Jonsen takes a similar line: "To the extent that medical care, on an assessed basis, can contribute to the health of individuals and thus improve the possibilities of self-respect and of equality, there is a moral obligation, arising from the basic moral obligations of respect and justice, to arrange social institutions so that care is available to all in equal need and so that such care can be provided in a manner conducive to self-respect. It can be said, then, that all persons have a moral right to medical care." Jonsen, "Health Care III...," in *Encyclopedia of Bioethics*, 628

[122] Libertarians give primacy to the individual rights to life, liberty and property. They see this as negative rights, i.e. one ought not be deprived of life, liberty or property. Liberal thinkers supplement the traditional civil and political rights with a set of social and economic rights, such as the right to social security or to an adequate standard of medical care. Communitarians emphasise that humans cannot possess any absolute human rights independent of and holding against society. Wellman, "Rights...," in *Encyclopedia of Bioethics*, 2308-2309

[123] Boyle, "The Developing...," in *Justice and Health Care*, 85. For a succinct history of the notion of "right" especially its use as "right to health care" see M. P. Golding, "Justice and Rights: A Study in Relationship" in *Justice and Health Care*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1981), 23-35 and L. B. McCullough, "Justice and Health Care: Historical Perspectives and Precedents" in *Justice and Health Care*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1981), 56-65. For an analysis of the "right to health care" and the presentation of a "quasi-libertarian" view see B. Brody, "Health Care for the Haves and Have Nots: Toward a Just Basis of Distribution" in *Justice and Health Care*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1981), 151-59

[124] C. Fried, "From 'Equality and Rights in Medical Care'" in *Ethics in Medicine. Historical Perspectives and Contemporary Concerns*, edited by S. J. Reiser, A. J. Dyck, and W. J. Curran,

be obliged to do all it can to provide conditions that enable an equal degree of health among all its citizens. This issue is basically ignored in much of American bioethical writing.

Viewed narrowly a right to health care aims at health. As such health is a perfection of bodily life, a component of human life, a basic good for humans.[125] It follows that:

> [o]ur entitlement to health care arises from the common commitment we have to the good of health. It follows that if a responsible moral agent's personal commitment to this good is lacking, his participation in the community of health seekers is, as it were, accordingly diminished, and his claim on the community's resources is to that extent weakened. The need for health care is thus not sufficient by itself to generate the right to health care. For those who are moral agents, a personal commitment to the good of health is also required.[126]

The right to health care necessitates that the community's pursuit of health through the specialisations of the medical profession be of benefit to each of the members of the community and at the same time be fair. The ordering of social priorities is a matter of social choice. It is, perhaps, more reasonable to suppose that a minimally decent level of health care is what the right to health care guarantees. In other words, members of a community have a right to *ordinary* health care - that is, to a fair share of what is available to the community at a given time. The basis for a fair distribution of health care resources is medical need or, more precisely, that level of need compatible with the fulfillment of the similar needs of other persons in the community. Egalitarians are correct to focus on a care that meets the basic health care needs of all.[127] For this reason the notion of a *decent minimum* of health care has been proposed. This notion should also include a humane environment of care for those who can not be cured. Obviously the notion of minimum care as a right is itself an unstable and changing notion. The concept of a decent minimum is always relative to what is available over all, and to what is judged to be the best available.[128]

(Cambridge, Mass.: The MIT Press, 1985), 581. The author further argues that for as long as our society considers that inequalities of wealth and income are morally acceptable, "it is anomalous to carve out a sector like health care and say that *there* equality must reign." (*ibid.*, 582)

125 J.M. Boyle, "The Concept of Health and the Right to Health Care" in *On Moral Medicine. Theological Perspectives in Medical Ethics*, edited by S.E. Lammers and A. Verhey, eds., (Grand Rapids, Mich.: William B. Eerdmans, 1987), 647

126 Boyle, "The Concept...," in *On Moral Medicine*, 647

127 Boyle, "The Developing...," in *Justice and Health Care*, 86

128 Fried, "From 'Equality..., in *Ethics in Medicine*, 583. Churchill declares a "*right to health care based on need means a right to equitable access based on need alone to all effective care society can reasonably afford* [author's emphasis]." Churchill, *Rationing...*, 94

The discussion of the right to health care outlined above offers a significant insight into the pressing concerns of U.S. bioethics. It also demonstrates the way in which earlier concerns with beneficence, philanthropy and altruism have been supplanted by justice concerns. It must now to be complemented by a consideration of the goals and limits of health care.

3.3 THE GOALS AND LIMITS OF HEALTH CARE

3.3.1 The Goals of Medicine and Health Care

Analysis of health care spending in a society necessitates consideration of a number of factors. First, the resources of the community itself, especially its long-term wealth and short-term income, are central. Second, the particular goals and objectives of the health care system must be understood. Third, there are the particular health care needs of the citizenry. Fourth are the resources and costs of attempting to achieve these ends. Finally, the competing social goods and duties of the community must be weighed.[129] The American bioethicist Paul Ramsey judged this last issue to be almost incorrigible to moral reasoning and rational determination. It must be resolved through political processes which reflect the values, preferences and priorities of the society.[130] The liberal state, however, as has been noted above excludes ultimate questions from consideration and any consensus as to the good of society. Such issues remain latent in all the political choices entailed in deciding the size of the health budget relative to the total national budget.

Therapeutic technologies in modern medicine mostly have life-saving, life-sustaining and life-enhancing potential.[131] In spite of many wonderful developments much of modern medicine must still be characterised as *half-way technology*, that is, capable of extending life but incapable of curing or restoring the patient to functional status.

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[129] A. Fisher, "The Principles of Distributive Justice considered with reference to the Allocation of Healthcare", D.Phil Thesis, Oxford University, 1994, 156. Fisher notes that various liberal theories do not take us very far towards a principled basis for determining total healthcare spending, partly because they cannot well answer the second and fifth issues. See also J. F. Childress, "Priorities in the Allocation of Health Care Resources" in *Justice and Health Care*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1981), 141

[130] Cf. Childress, "Priorities...," in *Justice and Health Care*, 141

[131] B. Jennett, "Treatment of Critical Illness in the Elderly", *The Hastings Center Report* 24:5 (1994): 21-22.

The problem of chronic illness remains.[132] The elderly are very often persons burdened with disabilities and chronic illnesses - the result of advances in acute, high-tech medical interventions.[133]

Human aging offers as good a place as any to observe the social consequences of medical progress. A shift has occurred in the primary goal of medicine in the course of this century from palliation to cure. Paralleling this has been the way the definition of health has enlarged its central focus on the body to include the entire well-being of the person. Static, nature-bound pictures of the possibilities of living a life have given way to a more open, wish-driven picture where nothing seems utterly impossible.[134] In light of these changes Daniel Callahan has proposed two distinct models for understanding the goals of modern medicine particularly in reference to the elderly. The first he calls *progressive incrementalism.* This approach to aging is dedicated to unlimited progress in the long run but cultivates small, incremental steps over the short term.[135] Progressive incrementalism is sustained by a belief that medicine has no final, inherent teleological goal for the elderly, that it can and ought to go as far as humanity wants it to go. There are no intrinsic biological limits and certainly no necessary moral limits. Average life expectancy can be increased to an unknown extent and there is no reason not to believe that an effective compression of morbidity is possible in the reasonably near future. Such incrementalism also has a social dimension that resists any attempt to view the aged as a discrete group. After all, in today's society, age is irrelevant as are height, colour and race:

> Progressive incrementalism . . . combines a view of medicine and its possibilities with a view of aging and its possibilities. They work together, each stimulating the other: medical progress provokes new visions of what old age could be, and what people hope for from old age is an impetus to medicine to provide it.[136]

Callahan designates the second approach as *life cycle traditionalism.* Here a harmony is sought between the present biological reality of the human life cycle and the

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[132] M. B. Kapp, "Health Care Tradeoffs Based on Age: Ethically Confronting the 'R' Word", *The Pharos* 52:3 (1989): 2

[133] Mark Siegler characterises modern medicine medicine as subject to bureaucratic parsimony which has three consequences: we dump the poor, blame the victim and kill the dying. M. Siegler, "Should Age Be a Criterion in Health Care?", *The Hastings Center Report* 14:5 (1984): 25-26.

[134] D. Callahan, "Aging and the Goals of Medicine", *The Hastings Center Report* 24:5 (1994): 40

[135] Callahan, "Aging...," *The Hastings Center Report,* 40; D. Callahan, "Aging and the Life Cycle: A Moral Norm?" in *A World Growing Old. The Coming Health Care Challenges*, edited by D. Callahan, R. H. J. ter Meulen, and E. Topinkova, (Washington, D.C.: Georgetown University Press, 1995), 22

[136] Callahan, "Aging and the Life Cycle..., in *A World Growing Old*, 23

feasible, affordable goals of medicine.[137] The goals of medicine are directed to help people remain in good health within the boundaries of a finite life span and to assist them to cope well with the poor health they may have. This approach provides a more modest view of medicine's appropriate goals. Instead of substantially improving the human condition life cycle traditionalist medicine has the goal of restoring and maintaining health within a limited time frame.[138] Old age thus comes to be seen as a biological stage in life which combines with a social status in society. The two are intertwined in a way that is true of every other age group in society.

In addition to considering the goals of medicine attention must also be paid to the type and purpose of the health care system in place in a particular society.[139] The extent of the literature on this question during the last decade indicates that it has engaged considerable attention among Americans writing in bioethics. In the U.S.A. funding and allocation of health care has traditionally been left to the free market with most Americans taking out private health insurance, usually inconjunction with their employer. Since the failure of President Truman to push national health insurance through Congress in 1949, successive presidents have tackled the issue either timidly or not at all. President Clinton has yet to achieve his goals for health care reform. Americans have embraced universal education yet have hesitated regarding health. The American Medical Association and various other interest groups have been very cautious on questions of universal health cover. Despite a huge government subsidy for health care (especially in the form of tax exemptions for employer contributions), Medicare and Medicaid programs, a disconcertingly large proportion of Americans are uninsured or under insured. Health care in the

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137 Feminist thinkers agree with three of Callahan's views on (a) mortality, (b) technological progress, and (c) medical needs. B. Spielman, "Achieving Equity and Setting Limits: The Importance of Gender" in *Facing Limits. Ethics and Health Care for the Elderly*, edited by G. R. Winslow and J. W. Walters, (Boulder, Co.: Westview Press, 1993), 184-186

138 Callahan, "Aging...," *The Hastings Center Report*, 40; Callahan, "Aging and the Life Cycle: A Moral Norm?" in *A World Growing Old*, 23-24

139 Cf. L. G. Pawlson and J. J. Glover, "Health-Care Delivery. I. Health-Care Systems" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 2, (New York: Simon & Schuster Macmillan, 1995), 1041-46; R. J. Bulger and C. K. Cassel, "Health-Care Delivery. II. Health-Care Institutions" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 2, (New York: Simon & Schuster Macmillan, 1995), 1046-49. Health care systems vary from the free market to the socialised. D. G. Gill, S. R. Ingman and J. Campbell, "Health Care Provision and Distributive Justice: End Stage Renal Disease and the Elderly in Britain and America", *Social Science and Medicine* 32:5 (1991): 565-77; H. T. Engelhardt, "Health Care Allocations: Responses to the Unjust, the Unfortunate, and the Undesirable" in *Justice and Health Care*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1981), 121-124; Engelhardt, *The Foundations of Bioethics*, 354-365. For a consideration of new approaches to health care systems such as HMOs and DRGs see F. H. Lowy, "Health Maintenance Organizations in Canada: Some Ethical Considerations", *Canadian Medical Association Journal* 139 (1988): 105-9.

U.S.A. is explicitly allocated on the basis of ability to pay, provider preference and, in government programs, on grounds of social disadvantage.

Any health care system is intended to meet health care needs and to do this in as just a way as possible.[140] The goal of health care is, quite simply, to meet needs.[141] To do so without reference to equality in access or efficiency in outcomes would be unjust.[142] But this does not mean that equality or efficiency are stand alone goals as measures of health care. A health care system is but one means of assuring equity of opportunity among citizens.

With an eye on health care for the aged it is important to note the ambiguity present in the term *basic care*. It is claimed and often assumed that care that is low-tech, preventive, primary and inexpensive is that which is both *basic* and morally prior to other forms of treatment. This claim is doubted by many and demands close scrutiny. Some authors argue that *an adequate level* of care is a more appropriate criterion.[143] Frequently in this area delivery of health care is judged in terms of a quality of life criterion that is based on an expected outcome for the patient which is assessed according to some standard of quality of life or well-being.[144]

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140 "This will *not* result in equal health, but it should result in equitable access to health care resources." Churchill, *Rationing...*, 128. For an acerbic view of the fallacies of health care and medicine see A. Wildavsky, "Doing Better and Feeling Worse: The Political Pathology of Health Policy" in *Bioethics*, revised ed., edited by T. A. Shannon, (Ramsey, N.J.: Paulist Press, 1981), 529-53

141 The distinction is sometimes made between *adventitious* needs and *course of life* needs. The basic needs that are considered the focus of health care are those whose fulfillment are essential for living and functioning normally in society. Cf. K. Nielsen, "Autonomy, Equity and a Just Health Care System" in *Biomedical Ethics*, 3rd. ed., edited by T. A. Mappes and J. S. Zembaty, (New York: McGraw-Hill, 1991), 563

142 On the issue of equality of access see President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, "An Ethical Framework for Access to Health Care" in *Biomedical Ethics*, 3rd. ed., edited by T. A. Mappes and J. S. Zembaty, (New York: McGraw-Hill, 1991), 569-571. Questions of efficiency have been discussed in terms of cost-benefit analysis and QALYs, see J. Avorn, "Benefit and Cost Analysis in Geriatric Care. Turning Age Discrimination into Health Policy", *The New England Journal of Medicine* 310:20 (1984): 1294-1301; J. La Puma and E. F. Lawlor, "Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers" and D. C. Hadorn, "The Oregon Priority-Setting Exercise: Quality of Life and Public Policy" in *Bioethics. Basic writings on the key ethical questions that surround the major, modern biological possibilities and problems*, 4th. ed., edited by T. A. Shannon, (Mahwah, N.J.: Paulist Press, 1993) 404-18, 424-425

143 The term chosen by the President's Commission. Cf. R. M. Veatch, "Should Basic Care Get Priority? Doubts About Rationing the Oregon Way", *Kennedy Institute of Ethics Journal* 1:3 (1991): 203

144 E. H. Morreim, "Life, Quality of. II. Quality of Life in Health-Care Allocation"; P. T. Menzel, "Economic Concepts in Health Care"; J. F.Kilner, "Health-Care Resources, Allocation of"; Campbell, C. S. "Utility" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, (New York: Simon & Schuster Macmillan, 1995), Vol.3, 1358-61; Vol.2, 649-57, 1067-84; Vol.5, 2509-13

3.3.2 The Limits of Medicine and Health Care

Human beings are mortal and resources are finite. This is a problem for society. Liberal thinkers view resource allocation as the conflict of rapidly expanding demands in the face of present and future scarcity. They assume that no change should take place in a society where individual freedom and human wants fuel a consumer economy.[145] In this context aging is viewed as a biological and social problem. Critics of the liberal approach, on the other hand, contend that a solution lies in a willingness to sacrifice the self-indulgent lifestyles of limitless consumption. Choices to use, withhold or withdraw medical technology are frequently ambiguous. A satisfactory philosophy of finitude is required grounded in the mutual character of obligations rather than in setting limits for one group in a society.[146] This provides the context and basis for any analysis of limits, allocation and rationing.

The terms *allocation* and *rationing* are frequently used interchangeably. These terms have been shaped by military experience.[147] The metaphor of warfare transforms the health care budget into a defence budget directed to conducting war against disease, trauma and death. The metaphor implies patterns of allocation within health care itself. A priority of critical care over prevention and chronic illness is implied in the war for health. Preference is given to certain diseases rather than others. Technical intervention is emphasised in favour of over-treatment for the terminally ill since death is viewed as the ultimate enemy. While *allocation* and *rationing* are inter-changed in current discourse they are also distinguished. *Allocation* frequently indicates how resources are distributed between different categories of goods and services. *Rationing* is applied to the distribution of health care resources to individuals or groups.[148] The term *distribution* as used in both notions does not necessarily imply a conscious agent, policy or decision. It refers rather to a result or outcome. Frequently there is such an agent, policy or decision as when a health care worker must choose between patients or treatments or a bureaucrat decides which hospital gets what. Commonly allocation occurs unintentionally, indirectly or *de facto* as an effect, possibly unforeseen, of the operation of the health system. These

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145 "[U]tilitarianism, pragmatism, and individualism are untouchable values." E. D. Pellegrino, "A Philosophy of Finitude: Ethics and the Humanities in the Allocation of Resources" in *Facing Limits. Ethics and Health Care for the Elderly*, edited by G. R. Winslow and J. W. Walters, (Boulder, Co.: Westview Press, 1993), 37

146 Pellegrino, "A Philosophy of Finitude...," in *Facing Limits*, 39

147 J. F. Childress, "Ensuring Care, Respect, and Fairness for the Elderly", *The Hastings Center Report* (1984): 30-31

148 L. G. Pawlson, J. J. Glover and D. J. Murphy, "An Overview of Allocation and Rationing: Implications for Geriatrics", *Journal of the American Geriatrics Society* 40:6 (1992): 629

institutions, policies and practices are themselves the result of a complex of deliberate choices by individuals working in governments, as insurers or within the professions. Even a choice to do nothing, to leave it to chance or leave it to the free market is a decision, and one which might be every bit as irresponsible or unreasonable as some positive or active choices. For these reasons distribution occurs either implicitly or explicitly, formally or informally.

The language of rationing is highly contentious in American society and health care. Harry Moody argues that the term rationing "belongs to the discourse of crisis, of extraordinary events"[149] and "is almost always a red herring that serves to confuse the debate on whether a specific allocation policy is wise or desirable."[150] The growing literature invoking the need for rationing in first world countries is misplaced. What is required are strict policies for health care allocation.[151]

Margaret Somerville notes that views of allocation or rationing will be governed by a number of factors.[152] First are perceptions of the characteristics that non-allocation decisions have when they impose harm or risk of harm. This harm may be judged to take place by choice or chance, directly or indirectly, by act or omission, by identified or unidentified allocators and to identified or unidentified allocatees. Second, rationing is often employed to overcome uncertainty. Third, attributing scarcity skews the questions and answers in the task of distribution. Fourth, it reinforces the idea that decisions are made about resources out there. In the case of aging it overlooks the fact that allocation and rationing decisions are made not "to" old people and in regard to the resources they will enjoy but must, because of our communal interdependence, involve allocation "with" an aging population.

Nancy Jecker approaches the issue of rationing by using resource-centered and patient-centered criteria. Resource-centered criteria treat specific aspects of health care resources as ethically important, such as the price resources command, the newness or technological sophistication resources display, or the rehabilitative,

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149 H. R. Moody, "Allocation, Yes; Age-based Rationing, No" in *Too Old for Health Care? Controversies in Medicine, Law, Economics and Ethics*, edited by R. H. Binstock and S. G. Post, (Baltimore: The Johns Hopkins University Press, 1991), 192

150 Moody, "Allocation, Yes...," in *Too Old for Health Care?*, 200

151 Moody, "Allocation, Yes...," in *Too Old for Health Care?*, 197. When "authorities at a higher level have made an allocation decision, it is always possible that lower-level officials may be tempted to introduce rationing, or other gate-keeping measures, as a means of coping with the shortage signalled by the higher-level budgetary or policy decisions. They may do it covertly (as in emergency room triage) or overtly (as with organ transplantation). However, rationing in the strict sense of the term, represents only one means of making allocation decisions." (*ibid.*, 198-199)

152 M. A. Somerville, "'Should the Grandparents Die?': Allocation of Medical Resources with an Aging Population", *Law, Medicine and Health Care* 14 (1986): 158-159

curative, palliative or preventive function resources serve. Resource-centered criteria ignore differences between persons and instead rest rationing decisions on features of health services themselves. In general, appeals to resource-centered criteria occur between different health care categories. Patient-centered rationing, on the other hand, claims to identify morally relevant qualities of individuals and to make these the determining ground of an individual's entitlement to health care. A person's age, ability to pay, place of residence, life expectancy, needs, past or future contributions, and lifestyle choices are examples of patient-centered standards. In general, appeals to patient-centered criteria occur within health care categories.[153] On the basis of this distinction Jecker developed four proposals governing the rationing of health care resources. She argues in favour of rationing high technology and non-basic services. Services to patients who receive the least medical benefit and services which are not equally available should also be rationed.

Health care distribution is frequently portrayed as occurring on three levels: (1) *macro-allocation* which seeks to answer the question: "How many resources should be devoted to health care?", (2) *meso-allocation* which asks: "What kinds of services should be provided out of these resources?" and (3) *micro-allocation* concerns itself with the question: "Who should get the health services provided?" These three areas are briefly considered at this point since the discussion situates the efforts of both Norman Daniels and Daniel Callahan to be studied in greater detail in the following chapter. Both authors concentrate on the issues involved in meso-allocation. Daniels' preoccupation is more restricted and formal. His intent is to provide a coherent and cogent rationale for the transition from his general theory of justice to concrete disribution policies through the use of middle order rules. Callahan, on the other hand, attempts to articulate general criteria that encourage an acceptance of limits in American society particularly as this applies to health care.

First is the issue of macro-allocation. The importance of social, political and economic frameworks must not be underestimated. While some may hold for a complete free market environment, even for health care, the majority accept some social obligation to provide health care.[154] Health care is a social good far beyond what individuals are able to provide through their own efforts. Because the need for health care is both unevenly distributed among persons and highly unpredictable and because the cost of securing it may be great few individuals can obtain it without

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[153] N. S. Jecker and R. A. Pearlman, "An Ethical Framework for Rationing Health Care" in *Bioethics. Basic writings on the key ethical questions that surround the major, modern biological possibilities and problems*, 4th. ed., edited by T. A. Shannon, (Mahwah, N.J.: Paulist Press, 1993), 527-528

[154] President's Commission, "An Ethical Framework...," in *Biomedical Ethics...*, 571-572

some mechanism for sharing costs. Differences in health status and health needs are mostly beyond an individual's control.

In addressing the second level or the meso-allocation concerns of health care the atomist/liberal view approaches the issues differently to that adopted by social/ communitarian thinkers. Norman Daniels proposed four questions for bridging the gap between his general theory and decision-making in the clinical setting. In his quest for *middle order rules* governing distribution of health care he asks: (1) how much should we favour producing the best outcome with our limited resources? (the fair chances/best outcomes problem); (2) how much priority should we give to treating the sickest or most disabled patients? (the priorities problem); (3) when should we allow an aggregation of modest benefits to larger numbers of people to outweigh more significant benefits to fewer people? (the aggregation problem); (4) when must we rely on a fair democratic process as the only way to determine what constitutes a fair rationing outcome? (the democracy problem).[155] A similar set of questions has been proposed by Kamm in terms of (1) individual versus social benefit; (2) here-and-now decisions versus long-term policy; (3) one-person decisions over time versus one-time decisions among multiple persons; (4) outcomes relevant to medicine versus broader social considerations; (5) part-of-life decisions versus whole-life decisions.[156] Convinced that there exists no shared intuition of the good life in U.S. society H.T. Engelhardt has argued that for health care to function properly it is imperative to (1) create a line defining needs as against desires; (2) decide the extent to which one will treat unfortunate circumstances as if they were cases of unfairness, and (3) anticipate the subversive nature of freedom.[157]

The above three approaches to the problems of meso-allocation well illustrate the atomist view of distributive justice that prevails in liberal first world societies. The criteria are proposed in terms of competing individuals, cost-benefit analysis and other elements of a utilitarian calculus.

A social or communitarian view perspective addressing the issue of limits and the allocation of scarce resources can be seen in Daniel Callahan's writings. For him a policy is "a set of priorities for action and the allocation of resources oriented toward

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[155] N. Daniels, "Meeting the Challenges of Justice and Rationing. Four Unsolved Rationing Problems. A Challenge", *The Hastings Center Report* 24:4 (1994): 27-29.

[156] F. M. Kamm, "Meeting the Challenges of Justice and Rationing. To Whom?", *The Hastings Center Report* 24:4 (1994): 29-32.

[157] Engelhardt, "Health Care Allocations...," in *Justice and Health Care*, 135

achieving a goal."[158] The allocation policies he has in mind must balance limits and aspirations in health care. He goes further however: allocation policies should in fact put limits on the aspirations of citizens. The dominant future policy bias in the system, Callahan contends, should be that of cultivating a sense of boundaries, finding ways of dampening unbounded hopes and enthusiasms, trying in particular to keep health aspirations firmly set within a broad perspective of the entire range of individual and social needs.[159] Two principles are proposed that would give the development of health care policy criteria a focus in favour of limits and restraint. The first is designated the *principle of health symmetry.* Any medical technology used must be judged by whether it brings about a good balance between the extension and saving of life on the one hand and the quality of life on the other.[160] This is further specified in terms of three goals which pursue: (1) medical research that promises a good long-term, overall outcome (at the lowest general cost, financial and otherwise); (2) those forms of health care that strike a good balance between the saving of life and the maintenance of a good quality of life; (3) those forms of health care and research that provide the best help for those already born with defects and handicaps, working to reduce the impact of illnesses already incurred.[161] The second principle proposed is the *principle of technology assessment.* Here both the successes and failures of medical developments must be recognised and evaluated. Callahan argues that society's primary task is to debate the moral, social and cultural ends we wish technology to serve. Only then will we be able to evaluate particular technologies.[162] Using these two principles as filters Callahan developed a six level priority schema moving from the provision of care in its most basic forms, e.g. pain relief (level 1), to food, sanitation etc. (level 2), to immunisations, antibiotics, (level 3), to emergency medicine, primary care (level 4), to advanced forms of medical cure and restoration (level 5), to the provision of highly advanced technological medical

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158 D. Callahan, *Setting Limits. Medical Goals in an Aging Society*, (New York: Simon and Schuster, 1987), 141. In a later work he writes that "A *policy* represents a general direction of thought and action, providing a basic framework for making decisions. It is *general* insofar as it does not map out in advance the exact choice to be made in each situation; it allows for contingencies and unforeseen, complicated developments. The policy has *direction*, however, insofar as it tries to affirm and express a given cluster of values and goals; these goals and values will pervade particular choices. As part of its direction, it will specify certain lines - the limits - that should not in the ordinary run of cases be crossed." D. Callahan, *What Kind of Life? The Limits of Medical Progress*, (New York: Simon and Schuster, 1990), 160.

159 Callahan, *What Kind of Life?*, 161

160 "Its aim is to promote medical coherence, by which I mean outcomes that foster the rounded well-being of persons, not simply one-dimensional improvements that benefit some aspect of individual well-being at the expense of others." Callahan, *What Kind of Life?*, 164-165

161 Callahan, *What Kind of Life?*, 165-166

162 Callahan, *What Kind of Life?*, 167-171

therapies, such as dialysis and open heart surgery (level 6).[163] For Callahan levels 1 to 4 should be given priority since they make the greatest contribution to the common good. At levels 5 and 6 severe limitations to individual needs have a place. In public policy terms the burden of proof for *not* providing health care at levels 1-4 lies with government. For the top two levels the onus of proof resides with the individual who must show that society should provide these forms of health care.

Certain standards are required to judge medical or health care at all six levels. Callahan suggests four such standards: whether (1) the public interest is served; (2) long-term care demand has been alleviated; (3) basic human needs have been met; (4) curative treatment is efficient and acceptable.[164] These standards provide a checklist for evaluating particular forms of curative medicine.[165] Their use requires that priority "be given to long-term benefits, and to meeting special age-group and socioeconomic needs."[166]

In addressing policy priorities in the care of the aged Callahan recognises that the health care system must, in addition to the above, provide equitable security for the elderly and frail. The following priorities in the care of the aged are important: (1) research into the causes of premature death; (2) enabling enhanced physical mobility, mental alertness and emotional stability in the lives of the aged; (3) medical care that alleviates chronic illness, pain and suffering; (4) concern for rehabilitation and prevention of illness; (5) provision of long-term, nursing and home care.[167]

The third, or macro-allocation, level of resource allocation focuses on clinical decision-making in situations where scarce life-saving resources are involved. In a detailed analysis of social, socio-medical, medical and personal criteria John Kilner has argued in favour of four criteria of medical benefit, (1) imminence of death, (2) likelihood of benefit, (3) length of benefit and (4) quality of benefit.[168] In situations where a number of people are equally in need of scarce life-saving therapies he proposes the two criteria of *medical need* and the *likelihood of benefit* from the medical intervention proposed.

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[163] Callahan, *What Kind of Life?*, 176-177

[164] Callahan, *What Kind of Life?*, 180-181

[165] "Similar sets of standards would be needed for the evaluation of proposed diagnostic procedures and technologies, and for research priorities.." Callahan does not develop these. Callahan, *What Kind of Life?*, 182

[166] Callahan, *What Kind of Life?*, 182

[167] Callahan, *Setting Limits*, 141-153

[168] J. F. Kilner, *Who Lives? Who Dies? Ethical Criteria in Patient Selection*, (New Haven: Yale University Press, 1990)

A two stage choice process is envisaged in the clinical situation.[169] Once a pool of persons is gathered after screening on the basis of medical need, further criteria must be employed especially when scarce life-saving resources are being used. Randomised choice, either by lottery or on a first come first served basis, is frequently proposed.[170] Imminence of a patient's death will be a criterion of selection in this second phase of clinical decision-making.[171]

The inquiry into the goals and the limits of medicine and health care pursued in this section provide a conceptual framework and outline the concerns that have preoccupied American health care throughout the last three decades. This background leads to a brief consideration of health care delivery in the U.S.A. and the way bioethics has rapidly assumed considerable importance in the American health care delivery system.

3.4 U.S. HEALTH CARE AND BIOETHICAL ANALYSIS

3.4.1 Health Care in the United States

This section sketches some of the realities and problem areas of health care delivery in the U.S.A. at present, in order to provide a context for analysis of the work of Daniel Callahan and Norman Daniels. Both have been heavily involved in the public debates about the social and political aspects of health care in their country especially in relation to care of the aged.

In the United States improved nutrition, medicine and public health have added twenty six years to average life expectancy since 1900. In 1985 average life

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[169] N. P. Rescher, "The Allocation of Exotic Medical Lifesaving Therapy" in *Biomedical Ethics*, 3rd. ed., edited by T. A. Mappes and J. S. Zembaty, (New York: McGraw-Hill, 1991), 598-607; J. F. Childress, "Who Shall Live When Not All Can Live?" in *Bioethics. Basic writings on the key ethical questions that surround the major, modern biological possibilities and problems*, revised ed., edited by T. A. Shannon, (Ramsey, N.J.: Paulist Press, 1981), 501-15.

[170] G.I. Mavrodes objects to the use of random procedures in the allocation of scarce life-saving medical resources. A fundamental assumption of this approach, he argues, is that there are no morally relevant differences among the candidates for such services. In rejecting this assumption he dismisses the general claim that resources should be distributed by lottery. In special cases where the assumption holds and a lottery is used the type of lottery chosen is selected on "valuational grounds". G. I. Mavrodes, "Choice and Chance in the Allocation of Medical Resources: A Response to Kilner", *Journal of Religious Ethics* 12:1 (1984): 97-115.

[171] J. F. Kilner, "A Moral Allocation of Scarce Lifesaving Medical Resources", *Journal of Religious Ethics* 9:2 (1981): 245-85

expectancy at birth was 74.6 years.[172] The dramatic increase in longevity in the first half of this century has slowed markedly:

> Between 1971 and 1976, for example, life expectancy at birth increased by 1.8 years; between 1981 and 1986, it was only 0.7 years, less than half as fast. At 65, the increase dropped from 0.9 to 0.2.[173]

In 1980 Americans 65 years and over constituted 11 per cent of the population.[174] By 1985 this had increased to 12 per cent or 28 million individuals.[175] By the year 2040, it has been projected that the elderly will represent 21 per cent of the population.[176] Paralleling the growth of the aged population has been an increase in the cost of health care. In 1980 the elderly, as 11 per cent of the population, absorbed 29 per cent of health care expenditure. By 1986 this had increased to 31 per cent and by the year 2040 it is projected to be 45 per cent of the health care budget.[177]

In light of these facts a number of points should be noted. First, the U.S.A. has a sizable elderly population which is likely to grow at a steady rate into the foreseeable future. Second, this elderly population is consuming health care dollars in an amount disproportionate to its size in the total population. Cost containment is frequently canvassed in the literature as a practical way of solving questions both of quantity and proportion in health care expenditure.[178] Third, care must be taken with the figures used throughout the debate. Clarification is required regarding the benchmarks used for measuring expenditure. Are the figures quoted for the gross national product (GNP) or gross domestic product (GDP), from private or public health care delivery? Fourth, cost escalation and an increasing elderly population are

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172 R. L. Sprott, "Policy Implications and Ethical Dilemmas Posed by an Aging Population" in *Life Span Extension. Consequences and Open Questions*, edited by F. C. Ludwig, (New York: Springer, 1991), 124

173 A. R. Somers, "Setting Limits or Promoting Health?" in *A Good Old Age? The Paradox of 'Setting Limits'*, edited by P. Homer and M. Holstein, (New York: Simon & Schuster, 1990), 102

174 D. Callahan, "Why We Must Set Limits" in *A Good Old Age? The Paradox of 'Setting Limits'*, edited by P. Homer and M. Holstein, (New York: Simon & Schuster, 1990), 23

175 Sprott, "Policy Implications...," in *Life Span Extension*, 124

176 Callahan, "Why We Must Set Limits" in *A Good Old Age?*, 24

177 Callahan, "Why We Must Set Limits" in *A Good Old Age?*, 23-24

178 Moskop argues that two conditions must be met before resort should be made to other criteria of rationing, e.g. age as in the case of Callahan. The two requirements are: (1) "we must have no effective method for controlling additional health care cost increases, and (2) we must be reaching the limits of our ability to absorb further cost increases." J. C. Moskop, "Confronting Health Care Rationing" in *Emerging Issues in Biomedical Policy. An Annual Review. Volume 1*, edited by R. H. Blank and A. L. Bonmicksen, (New York: Columbia University Press, 1992), 105

often linked so as to give focus and urgency to the economic crisis confronting U.S. health care.[179]

A number of causes for cost increases in American health care have been suggested. In order of importance they are (1) price increases and inflation, (2) higher intensity of services and increased technology and (3) population changes.[180] Provision of health care services is regarded by many as a very attractive seller's market where there is high demand, high levels of third party reimbursement with little direct financial sacrifice by most consumers and relatively weak competitive or regulatory forces constraining providers. There is, in other words, relatively little to prevent providers and suppliers from maximising their own financial interests.[181] The reasons for rising costs in health care are well understood. They lie in (1) structural incentives built into pluralistic financing (there is no single uniform payer-control mechanism), (2) regulatory and administrative costs of a complex and multi-layered system, (3) fee-for-service payment for physicians and a licence to extra bill, (4) a retrospective cost-based system, (5) marketing costs and profit making in a largely private medical care delivery system.[182]

Public policy in the U.S.A. has promoted health care in the private sector. It has done so in a number of ways including (1) the creation of productive opportunities for private investment in health care and (2) the restriction of state activities in health and social services to those that support and complement the market; this is achieved by financing limited programs of health insurance while at the same time also providing 40 per cent of U.S. health-care spending, through the expansion of costly, but profitable, medical-industrial complex; (3) the engagement by the state in market-replacing actions to stimulate economic growth, and (4) the reduction of state

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179 Binney and Estes point to the facts of health care expenditure to counter the language of crisis: "the United States ranks considerably behind almost every major industrialized country in terms of *public sector* health expenditures as a percentage of the GDP (gross domestic product)- 4.4 per cent - ahead of only Spain, Portugal, and Greece. The United States also ranks dead last among major industrialized countries in public health expenditure as a percentage of total health expenditure at 41.1 percent, with the mean percentage at 78.1 percent. Nevertheless, the United States spend a higher total health expenditure (from combined public and private sources) as a percentage of GDP (10.8 percent) than any other of these same countries." E. A. Binney and C. L. Estes, "Setting the Wrong Limits: Class Biases and the Biographical Standard" in *A Good Old Age? The Paradox of 'Setting Limits'*, edited by P. Homer and M. Holstein, (New York: Simon & Schuster, 1990), 248

180 Binney and Estes. "Setting the Wrong Limits...," in *A Good Old Age?*, 250. Moskop adds government programs to this list. Cf. Moskop, "Confronting...," in *Emerging Issues...*, 103-104

181 Moskop, "Confronting...," in *Emerging Issues...*, 105

182 Binney and Estes. "Setting the Wrong Limits...," in *A Good Old Age?*, 249

support for social and community-care services; these services tend to be less profitable avenues of private investment.[183]

Medicare and Medicaid are the principal public programs affecting elderly Americans. They were established by Congress in 1965 to give health care benefits to the elderly equivalent to those enjoyed by most working Americans at that time. Escalating costs in both programs have added significantly to the health budget.[184] President Regan extended the scope of public funding when he signed the *Catastrophic Health Insurance Act of 1988*. This Act is defective in that it will benefit an estimated 15 percent of long-stay hospital patients not already protected. At the same time a marginal expansion of home-care benefits is sharply limited. The Act addresses the narrow, hospital-based, high-technology corner of the problem and does nothing for the larger non-hospitalised population. In general, the current system encourages costly hospitalisation but fails to address the out-of-hospital needs for regular primary care and other aftercare alternatives.[185]

The preeminence of "for profit" health care systems, fee-for-service health care delivery, acute, high-technology hospital care has made it extremely difficult for the U.S.A. to confront the needs of the chronically ill and permanently disabled.[186] It is no exaggeration to say that many factors in American health care make the provision of long-term care for the elderly and disabled very difficult. In addition to these structural elements diseases of old age (e.g. Alzheimer's disease, stroke, osteoporosis, arthritis) together with incontinence, memory loss and immobility coallesce to create pressures for the provision of costly long-term care.

A number of imbalances in U.S. aged care should be noted here. Research spending on aging has low priority. Perry and Butler argue that "of the $167 billion a year spent on health care for people over age 65, far less than one half of 1 percent of that amount is reinvested in research that could lead to lower health care costs for chronic

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183 Binney and Estes. "Setting the Wrong Limits...," in *A Good Old Age?*, 247

184 Callahan points to an annual Medicare cost rise from $75 billion in 1986 to $114 billion by the year 2000. The latter figure is in current not inflated dollars. Callahan, "Why We Must Set Limits" in *A Good Old Age?*, 24

185 R. Morris, "Balancing Our Capacity to Hope with Our Need to Cope: the Role of Science in Creating Health-Cost Dilemmas" in *A Good Old Age? The Paradox of 'Setting Limits'*, edited by P. Homer and M. Holstein, (New York: Simon & Schuster, 1990), 210

186 It is beyond the scope of this thesis to explore the nature of Social Security in the U.S. It is fair to say, however, that the limits of this system reinforce the specific difficulties in health care outlined in the text.

diseases and disabilities."[187] Furthemore, government investment in research that could improve *current* care in nursing homes or private homes goes instead to research on possible *future* solutions for chronic conditions. Preference is given to the funding of technological solutions to social and personal problems of chronic illness but little or no attention is given to improving the long-term social-support systems that are an integral part of health care for the general aged population.[188]

Americans place a very high value on health and the curative powers of medicine. They tend to view health as an end in itself and not merely a means to a good life. They place great faith in the unlimited potential for progress in high-technology medicine and expect the benefits of modern medicine to be readily available. In fact they claim a right to the best that medicine has to offer.[189]

The issue of intergenerational equity appears frequently in discussions about just health care for the aged. This will be analysed in detail in chapter 5. Generational equity suggests that all age groups and generations have a right to fair treatment and that benefits for one group (e.g. the elderly) should not be advanced without carefully considering the competing needs and rights of other groups.[190] Two general comments are relevant here. First, America's younger generation are said to be suffering as a consequence of the aged population's size and affluence. The statistics, it is argued, support this perception. The elderly who are 12 per cent of the population consume 30 per cent of the national health care budget. A similar situation exists when it comes to considerations of rich and poor in America. A much more affluent aged population is far better off than blacks and children who live below the poverty line. Caution needs to be exercised here regarding the figures quoted. The divergent trends in poverty rates of children and the elderly are due, experts say, to two different and largely independent causes.[191] A second dimension of the problem of an aging population is to be found in the increase in dependency ratios between old and young. The dependency ratio peaked in the U.S.A. in the mid-1960s. The dependent group at that time was primarily children born after World

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[187] D. Perry and R. N. Butler. "Aim Not Just for Longer Life, but Expanded 'Health Span'" in *A Good Old Age? The Paradox of 'Setting Limits'*, edited by P. Homer and M. Holstein, (New York: Simon & Schuster, 1990), 93

[188] Morris, "Balancing...," in *A Good Old Age?*, 209

[189] Moskop, "Confronting...," in *Emerging Issues...*, 105

[190] Cf. M. Minkler, "Generational Equity and the Public Policy Debate: Quagmire or Opportunity?" in *A Good Old Age? The Paradox of 'Setting Limits'*, edited by P. Homer and M. Holstein, (New York: Simon & Schuster, 1990), 222-223

[191] Government policies, especially improvements in Social Security have affected the lot of the elderly for the better. Market forces such as decline in wages and an increase in unemployment have contributed to an increase of poverty among children in the U.S.

War II. A dependency ratio with the elderly as the dependent group will not reach similar levels until the middle of the next century.[192] This transition requires that consideration be given to the way financial burdens are redistributed as the dependency ratio changes. Individuals, families, local and state governments carried the burden of dependency during the 1960s. As the shift to a greater proportion of dependent elderly occurs funding for their care falls on the federal government. This shift from the private to federal realms contributes to an altered awareness of the problem and adds to the sense of urgency when an increase of elderly population is discussed in intergenerational terms. In this the American situation differs little from that occurring in Australia.[193]

One of the consequences of high aged dependency ratios is the role families, and women especially, play in the care of elderly parents and relatives. This too will be re-visited in detail in chapter 5 below. It is sufficient here simply to mention that in the U.S.A. today families provide eighty to ninety percent of elder care. Very often it is adult daughters and daughters-in-law who provide the greater part of this cross-generational care giving.[194]

The notion of rationing is abhorrent to the American psyche. This may be because it sees itself as a land of plenty. Nevertheless while rationing of health care resources is a fact of every day life and exists in many forms "including rationing by price, central authority, disease, age, race, and merit, a class-based rationing system (with elements of deservingness) dominates."[195]

3.4.2 American Bioethics.

The term *bioethics* was first used in a published article by Van Rensselaer Potter in 1970 and by Andre Hellegers in an institutional way the following year to designate a particular area of inquiry or field of learning.[196] Warren Reich has argued with great detail and persuasion that "the name of this field experienced a bilocated birth, in

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[192] Sprott, "Policy Implications...," in *Life Span Extension*, 125

[193] See chapter 1.6.2.2

[194] Minkler, "Generational Equity…," in *A Good Old Age?*, 227-228

[195] Binney and Estes. "Setting the Wrong Limits…," in *A Good Old Age?*, 243

[196] Cf. V. R. Potter, "Bioethics, the Science of Survival", *Perspectives in Biology and Medicine* 14 (1970): 127-53; V. R. Potter, *Bioethics, Bridge to the Future*, (Englewood-Cliffs, N.J.: Prentice-Hall, 1971); V. R. Potter, "Aldo Leopold's Land Ethic Revisited: Two Kinds of Bioethics", *Perspectives in Biology and Medicine* 30:2 (1987): 157-96; W. T. Reich, "How Bioethics Got Its Name", *The Hastings Center Report* 23:6 (1993): S.6

Madison, Wisconsin, and in Washington, D.C."[197] In the intervening twenty five years bioethics has matured into a minor form of moral philosophy practiced within medicine.[198] A number of theologians, especially Joseph Fletcher and Paul Ramsey, contributed to the rebirth of medical ethics in the U.S.A. during the period 1965-1975.[199] Institutional foundations for the new field of bioethics were laid in 1969 by Daniel Callahan and others at the *Hastings Center* at Hastings-on-Hudson, New York, and shortly after by Andre Hellegers who was the driving force in establishing the *Kennedy Institute of Ethics* at Georgetown University, Washington, D.C. [200] In the years since 1975 bioethics has become a native grown American product:

> Modern bioethicists react to medicine, medical technology, and health care services with peculiarly American concerns about the rights of individuals, fairness and equity and access to benefits, and secularized reflections about death, abortion, suffering, and aging. Additionally, as Callahan also noted, the resolution of many of these problems had been peculiarly American, namely, the devising of regulations and guidelines.[201]

In this same period moral philosophers became increasingly involved in the bioethical project and have given it a particular orientation during the last two decades. [202] It is helpful here to sketch some of the prevailing philosophical emphases that permeate much recent American writings in bioethics. Renee Fox has observed that the "values and beliefs highlighted by American bioethics represent a particular cross section of the society's cultural tradition."[203] She highlights the priority given to individualism and singles out the notions of contract and truth-telling. Included also is a concern about just and fair distribution of scarce resources with a related emphasis on cost containment. Finally much attention has been given to the principles of beneficence or benevolence. In her analysis of the contemporary

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197 W. T. Reich, "The Word 'Bioethics': Its Birth and the Legacies of Those Who Shaped It", *Kennedy Institute of Ethics Journal* 4 (1994): 320. Reich's detailed outline history of the origins of the term *bioethics* points to independent, yet not completely, unrelated coining of the term by Potter, Sargent Shriver and Hellegers (*ibid.*, 324-328)

198 A. R. Jonsen, "The Birth of Bioethics", *The Hastings Center Report* 23:6 (1993): S.1

199 L. Walters, "Religion and the Renaissance of Medical Ethics in the United States: 1965-1975", in *Theology and Bioethics. Exploring the Foundations and Frontiers*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1985), 3-16. See also J. Fletcher, *Morals and Medicine*, (Princeton, N.J.: Princeton University Press, 1954) and P. Ramsey, *The Patient as Person: Explorations in Medical Ethics*, (New Haven: Yale University Press, 1970)

200 The Hastings Center originally began as *The Institute of Society, Ethics and the Life Sciences*.

201 Jonsen, "The Birth...," *The Hastings Center Report*, S.3-S.4

202 S. Toulmin has argued that growth of bioethics rescued moral philosophy from the wilderness of metaethical inquiry in S. Toulmin, "How Medicine Saved the Life of Ethics", *Perspectives in Biology and Medicine* 25 (1982): 736-50.

203 R. C. Fox, "The Sociology of Bioethics" in *The Sociology of Medicine. A Participant Observer's View*, (Englewood Cliffs, N.J.: Prentice Hall, 1990), 229

bioethical ethos Fox has pointed out that the discipline operates with a restricted definition of *persons as individuals* and *persons in relations.* In effect this has resulted in the downplaying of values such as decency, kindness, empathy, caring, devotion, service, generosity, altruism, sacrifice and love.[204] She rightly observes that:

> there is a sense in which bioethics has taken its American societal and cultural attributes for granted, ignoring them in ways that imply that its conception of ethics, its value system, and its mode of reasoning transcend social and cultural particularities. In its inattention to its 'American-ness' and its assumption that its thought and moral view are *trans*cultural, American bioethics has been more intellectually provincial and chauvinistic than it has recognized.[205]

Because of the prevailing philosophical, medical and legal emphases in contemporary American bioethics it has been both pragmatic and reductionist. This has resulting in the religious dimension of many medical issues being ignored. Fox has also observed that concrete bioethical problems are "discussed in technical, unemotional, nonmetaphorical language, and in a rigorously rational, formal, largely deductive mode of argumentation framed by a 'relatively small set of concepts' - chiefly the principles of respect for autonomy, beneficence, nonmaleficence, and justice, and the derived rules of truthfulness, privacy, confidentiality, and fidelity."[206]

Reaction to the dominant ethos within the American bioethics community parallels dissatisfaction among European scholars regarding the prevailing American way of doing bioethics.[207] For example, it has been argued that Mediterranean countries are able to contribute to bioethical reflection through their concern for the understanding of the person, the active role of the family in managing situations of conflict and the emphasis they place on trust as the foundation of the doctor-patient relationship.[208] This critique will perhaps gain momentum as various centres of bioethical research

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204 Fox, "The Sociology...," in *The Sociology of Medicine*, 229-231

205 Fox, "The Sociology...," in *The Sociology of Medicine*, 231

206 R. Fox, "The Entry of U.S. Bioethics into the 1990s: A Sociological Analysis" in *A Matter of Principles? Ferment in U.S. Bioethics*, edited by E. R. DuBose, R. P. Hamel, and L. J. O'Connell, (Valley Forge, Pa.: Trinity Press International, 1994), 48

207 A. Jonsen and S. Toulmin propose a new casuistry, J. Drane and A. MacIntyre argue for virtue ethics; other scholars emphasise hermeneutics, phenomenology, feminist perspectives, the role of the social sciences as well as that of theology.

208 Fox, "The Entry...," in *A Matter of Principles?*, 59-60

begin to flourish in Europe, Canada and South America and confront medical issues from within their own particular cultures.[209]

Reich's recent study of the origins of the term *bioethics* began with an hypothesis. It accepted differences between Potter's understanding of the term and that held by Hellegers' in Washington. The latter's understanding of the term came to be more widely accepted.[210] Reich's investigation, however, led to an unanticipated conclusion, namely, that Hellegers (in contrast to the dominant model offered by the Georgetown scholars) actually proposed a global approach to bioethics. His vision was, therefore, much closer to Potter's evolving understanding of the term. The Georgetown *model* of bioethics, focusing as it did on concrete medical dilemmas, has exercised a dominant influence on the evolving discipline. In fact it revitalised the study of medical ethics in the U.S.A.. This effectively marginalised the global vision that motivated Potter's agenda.[211] Reich's study has argued that both Hellegers and Potter espoused a global approach to bioethics in all three senses of the term *global*. While the insight gained from Reich's study is informative and enlightening, its implications are of particular value for the direction of this thesis. Reich has argued that, without a global framework for bioethics, the more narrowly conceived, medically-oriented bioethics of the last quarter century easily becomes a restricted list of disconnected issues and arguments about issues. It tends to medicalise the entire field of bioethics, shaping questions and perceptions according to the dominant American culture. An excessive medical orientation has also tended to marginalise the ethics of nursing and other health professions. Most importantly, however, has been its effect on the ill and the family, friends and communities that care for them.[212] Reich concludes that, in the light of its origins, bioethics is best defined in its global sense, as the ethics of the life sciences and health care. Adjectives will then specify

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209 G. Russo, "Storia della bioetica" in *Dizionario di Bioetica*, edited by S. Leone and S. Privitera, (Acireale: EDB-ISB, 1994), 950-953; C.Viafora, ed., *Vent'anni di Bioetica*, (Padova: Fondazione Lanza, 1990), 178-434

210 W. T. Reich, "The Word 'Bioethics': The Struggle over Its Earliest Meanings", *Kennedy Institute of Ethics Journal* 5:1 (1995): 20

211 Reich discerns three dimensions of *global*: (1) relating to or involving the entire earth: a worldwide ethic for the good of the world; (2) entailing the comprehensive inclusion of all ethical issues in the life sciences and health care, i.e. the biomedical and environmental issues in the debate; (3) utilising a comprehensive vision of methods for approaching these issues: incorporating all relevant values, concepts, modes of reasoning and disciplines. W.T. Reich, "The Word 'Bioethics': The Struggle over Its Earliest Meanings", *Kennedy Institute of Ethics Journal* 5:1 (1995): 24

212 Reich, W. T. "The Word 'Bioethics': The Struggle...," *Kennedy Institute of Ethics Journal*, 24

particular areas of concern within the discipline, such as *medical* bioethics, *environmental* bioethics.[213]

This study now turns to two significant participants in the secular terrain of American bioethics. The complex of issues considered in this chapter have provided sufficient detail to understand their preoccupations and intentions. Chapter 3 has also illustrated a central theme of this thesis that discussion of particular medical or health care issues should not and must not be divorced from wider community and global concerns.

3.5 SUMMARY AND CONCLUSIONS

3.5.1 Summary

Recent bioethical analyses of just health care for the elderly gained prominence in the English speaking world through the contributions of two American bioethicists, Norman Daniels and Daniel Callahan. This chapter has provided an understanding of the political, health care and bioethical contexts that have shaped the work of Daniels and Callahan to be considered in chapters 4 and 5. Attention was given first to the notions of liberalism and justice underpinning the American society within which they function. Concepts relevant to care for the neighbour, namely beneficence, philanthropy, altruism, rights were next considered in some detail. This study identified the long held emphases within western medical practice that have been significantly altered, or even undermined, through the growth of contemporary scientific medicine and health care. A brief consideration of the goals and limits of contemporary medicine illustrated dimensions of the earlier discussion on beneficence when health care confronts the complexities and limits of social life. This inquiry was further specified by considering the particularities of U.S. health care and bioethical analysis. Chapter 3 thus offers a detailed picture of the particular historical and cultural contexts of American health care adequate for an appreciation

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[213] Reich, W. T. "The Word 'Bioethics': The Struggle...," *Kennedy Institute of Ethics Journal*, 29-30. Reich observes, furthermore, that the field of bioethics "originated with the word *bioethics*, in part because the word itself symbolized and stimulated an unprecedented interaction of biological, medical, technological, ethical, and social problems and methods of thinking. Significantly, the word *bioethics* played a major role in creating a new forum and a new platform from which to speak, displacing the suspicions of sectarianism and religious ideology previously suggested to the public mind by the word *ethics*. The word had the wonderfully innovative effect of creating an acceptable secular terrain - both within academe and in the public forum - where scientific, health-related, religious, philosophical, and social and political ideas could meet and create a new, multidisciplinary mode of inquiry." (*ibid.*, 30-31)

of the contribution of Daniels and Callahan to be studied in the following two chapters.

3.5.2 Conclusions

1. The brief outline of the concepts of liberalism and justice in this chapter enables us to conclude

    - that the liberal agenda is fundamentally analytic, reductionist and thin-textured,
    - that the imperatives of the liberal state narrow the framework for ethical analysis with implications for just health care for the elderly, and
    - that liberal theory has difficulty incorporating a social view of justice, communitarian perspectives and concerns about the common good;

2. Through the richly textured set of concepts used to explore care for the neighbour, namely beneficence, philanthropy, altruism and rights I have argued that

    - in modern times these notions have been progressively emptied of their original substantive meanings;
    - the paradigm case of the parable of the Good Samaritan has had an influential and important role through history in articulating the dimensions of care for the neighbour whether this be portrayed in terms of beneficence, philanthropy or altruism;
    - in place of the narrow conceptions of codes and social contracts in contemporary medicine another significant and more satisfactory vision is offered by the notion of *covenant*;
    - a renewed appreciation of the notions of community, samaritanism and covenant will contribute to public policy regarding just health care for the elderly.

3. In considering the goals and limits of contemporary medicine and health care I argue that individual and societal aging, and the health care required by this phenomenon, demand a re-evaluation of what health care can and ought offer. Deciding on the type of basic care to be delivered in a publicly funded health care system is part of this task.

4. The brief description of the particularities of U.S. health care and bioethical analysis permit me to argue that

    - many problems in U.S. health care arise directly from the priorities and preoccupations of American liberal democracy;

    - the analysis of resource allocation and rationing in much English language bioethical literature is shaped by the particularities of American liberalism, jurisprudence and philosophy and ignores social views of justice, communitarian perspectives and the common good agenda.

    - reductionist or *principlist* bioethical analysis dominant in the U.S.A. until recently has excluded broader philosophical considerations such as virtue ethics and theological personalism. These two dimensions will be shown in Part III to have an important role in just health care for aged persons.

CHAPTER 4

TWO PROPONENTS OF JUST HEALTH CARE

4.1 The Contribution of Norman Daniels 176

- 4.1.1 Just Social Policy 176
  - 4.1.1.1 Daniels as Health Care Reformer 176
  - 4.1.1.2 The American Context 178
  - 4.1.1.3 Rationing Health Care 179
- 4.1.2 Health Care 181
- 4.1.3 Explanatory Framework 184
  - 4.1.3.1 The Rawlsian Approach to Justice 184
  - 4.1.3.2 Extending Rawls' Theory to Health Care 185
  - 4.1.3.3 Equity of Access to Health Care 187
  - 4.1.3.4 The Prudential Lifespan Account 188

4.2 The Contribution of Daniel Callahan 193

- 4.2.1 Callahan's Philosophical Agenda 193
  - 4.2.1.1 Reflecting Bioethically 193
  - 4.2.1.2 Technology 197
  - 4.2.1.3 The Individual and the Common Good 204
- 4.2.2 Human Experiences Throughout the Life Span 208
  - 4.2.2.1 Health and Illness 208
  - 4.2.2.2 Aging 217
  - 4.2.2.3 Dying and Death 224
- 4.2.3 Resource Allocation and Rationing of Health Care 226

4.3 Summary and Conclusions 229

- 4.3.1 Summary 229
- 4.3.2 Conclusions 229

CHAPTER 4

TWO PROPONENTS OF JUST HEALTH CARE

The particular historical and cultural context of American health care and bioethics have been outlined in chapter 3. It is against this background that two apologists for just health care, namely Norman Daniels and Daniel Callahan, are to be understood. Both have been actively involved in the health care and bioethical debates in the U.S.A. during the last quarter century. Chapter 4 provides a detailed outline of their thinking on just health care for the elderly, on the basis of their published articles and books. As mentioned earlier, Daniels presents his thinking within an atomist or liberal model, Callahan offers a communitarian perspective.

The exposition that follows is attentive to the foundational ideas that each author has used in building his particular approach to justice and issues of health care for the aged. Daniels explicitly adopts the Rawlsian rationale of justice-as-fairness and applies it specifically to the health care arena. In doing this he articulates the two principles of *equity of access* and the *prudential lifespan account*. This enables him to analyse justice questions relating to health care in an aging population. Callahan, on the other hand, adopts a broader humanistic and philosophical approach. Rather than starting with a recognised justice theory, as Daniels does, he analyses the moral values and assumptions of contemporary American society. This provides him with particular emphases as he approaches issues of resource allocation and rationing within health care.

Chapter 4 does not attempt to engage the contributions of both authors in a critical fashion. Rather, its purpose is to provide an accurate and detailed account of each author's thought in a manner not presently available in current literature. Once this has been done their specific contributions on justice questions will be analysed in critical detail in chapter 5.

4.1 THE CONTRIBUTION OF NORMAN DANIELS

4.1.1 Just Social Policy

4.1.1.1 Daniels as Health Care Reformer

Health care reform in the U.S.A. was given a high profile during President Clinton's first term in office. Norman Daniels' participation in the Ethics Working Group of Clinton's Health Care Task Force points to a philosopher who is commiteed to the work of practical ethics. Daniels has for some time been concerned with the issues of health care, justice and public policy particularly as this applies to the elderly.[1]

Writing about the work of the Ethics Working Group, Daniels indicates fourteen principles and values he considers central for reorganisation of the U.S. health care system.[2] A number of these have an important role in his own writings: health care is of fundamental moral importance; everyone must have access to health care services; there must be equal benefits and fair burdens; the health care system must respond to our needs at each stage of our lives; resources must be allocated that meet our most important needs. In addition to effective treatment, quality care and efficient management of the system, individual choice, personal responsibility, professional integrity and fair procedures must be assured.

Big-ticket technologies and organ transplantation were two issues concentrating Daniels' attention during 1988 and 1989. The question he asked at that time was whether the availability of high tech procedures such as organ transplants should be extended in the American health care system. He rejected the utilitarian argument favouring the greater aggregate medical benefits achieved through investing resources in such technology. Advanced technologies should be weighed against alternatives to judge their overall impact. The basis of judgment should be fair equality of opportunity. Social obligations to provide just health care must be met within the conditions of moderate scarcity. This, he argued, is not an approach that

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[1] The "applied philosopher must be clear about what policy question is really being asked and then be sure he knows the limits of his theory and its application....At the same time, it is fair to say that philosophers cannot rest content with claims about the loftiness of their vision. We owe a special effort to develop better philosophical equipment to address questions in a non-ideal world not always bent on basic reform." N. Daniels, *Just Health Care*, (Cambridge: Cambridge University Press, 1985), 229

[2] N. Daniels, "The Articulation of Values and Principles Involved in Health Care Reform", *The Journal of Medicine and Philosophy* 19 (1994): 425-33.

gives individuals a basic right to have all their health care needs met. There are social obligations to provide individuals only with those services integral to a system that, on the whole, protects equal opportunity.[3] Daniels' notion of *fair equality of opportunity* will be discussed below as will his analysis as to why *opportunity costs* arguments have failed within the American health care scene.

Daniels discussed organ transplants in two other contexts. He first analysed an individual's ability to pay for access to such technologies. What troubles him is "not the public nature of the organs nor that we encourage a gift that some will not be eligible to receive, but the consequences of the inequality of access, and that is a different point."[4] Because organ transplants have very high costs and problematic *opportunity costs*, that is, compared to many other medical treatments they deliver a significant benefit to relatively few people at relatively high cost, it may be argued that the health care dollar is more effectively used promoting normal functioning and other opportunities.[5] Daniels' second approach to organ transplants developed when he took issue with Daniel Callahan as to whether organ repair has altered the *natural baseline* of human existence.[6] He views medical assistance in this area as not altering the fundamental features of personhood and personal identity. Even a brain transplant merely compensates for normal species-typical functioning.[7]

During 1991 and 1992 Daniels explored the Oregon rationing plan. For him the Oregon plan seemed to reject the prevailing strategy for rationing in the U.S.A. This rationing system excluded whole categories of the poor and near-poor from access to public insurance, denying coverage to *people*, rather than to low-priority *services*. The Oregon plan proposed different principles:

> (1) there is a social obligation to guarantee universal access to a basic level of health care, (2) reasonable or necessary limits on resources mean that not every beneficial service can be included in the basic level of health care, and (3) a public process, involving consideration of

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3 N. Daniels, "Justice and the Dissemination of 'Big-Ticket' Technologies" in *Organ Substitution Technology. Ethical, Legal, and Public Policy Issues*, edited by D. Mathieu, (Boulder, Co.: Westview Press, 1988), 214; N. Daniels, "Comment: Ability to Pay and Access to Transplantation", *Transplantation Proceedings* 21:3 (1989): 3424-25

4 Daniels, "Comment..." *Transplantation Proceedings*, 3424

5 Daniels, "Comment..." *Transplantation Proceedings*, 3425

6 For a critical review of both authors and their understanding of *nature* see N. S. Jecker, "Appeals to Nature in Theories of Age-Group Justice", *Perspectives in Biology and Medicine* 33:4 (1990): 517-27

7 N. Daniels, "Technology and Resource Allocation: Old Problems in New Clothes", *Southern California Law Review* 65:1 (1991): 226-227

> social values, is required to determine what services will be included in the basic level of health care.[8]

Daniels criticised two features of the Oregon plan. First, he viewed it as restricting rationing to the poorest groups in society. Poor women and children who constitute 75 per cent of Medicaid recipients receive only 30 per cent of the benefits offered by the scheme. The elderly, because of their political clout, have ensured that their benefits are not included in the prioritisation involved in the plan.[9] This illustrates for him the structure of inequality in the U.S. health care system. Second, Daniels finds fault with the procedures adopted in the Oregon experiment. Not only were the community meeting processes used to develop the plan defective, little or no attention was given to unresolved moral issues implicit in the ranking process.[10]

4.1.1.2 The American Context

The U.S. health care system is the context for all that Norman Daniels discusses in his published writings. Two features of this system pose difficulties for him:

> We allow health care institutions to operate competitively instead of requiring them to act cooperatively and collectively. Also, we do not force each institution to pay the price of introducing technologies with high problematic opportunity costs.[11]

In his review of Paul Starr's *The Social Transformation of American Medicine* Daniels locates the escalating costs problem of U.S. health care in past concessions to the medical profession. Retention of fee-for-service and retrospective reimbursements in both public and private insurance schemes are seen to be the culprits together with the preeminent role given to physician autonomy:

> Physicians can locate where they will, specialize as they choose, and treat whom they want. Their autonomy leaves many needs unmet and many people without access to the kind of care they need - or to any at all.[12]

What results is a basic tension between medical autonomy on the one hand and equitable access to health care at reasonable social cost on the other. Daniels

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8 N. Daniels, "Is the Oregon Rationing Plan Fair?", *Journal of the American Medical Association* 265:17 (1991): 2232

9 Daniels, "Is the Oregon…," *Journal of the American Medical Association*, 2233

10 N. Daniels, "Justice and Health Care Rationing: Lessons from Oregon" in *Rationing America's Medical Care: The Oregon Plan and Beyond*, edited by M. A. Strosberg, J. M. Wiener, R. Baker, and I. A. Fein, (Washington, D.C.: The Brookings Institute, 1992), 185-95.

11 N. Daniels, "A Lifespan Approach to Health Care" in *Aging and Ethics. Philosophical Problems in Gerontology*, edited by N. S. Jecker, (Totowa, N.J.: Humana Press, 1992), 244

12 N. Daniels, "Understanding Physician Power: A Review of The Social Transformation of American Medicine'", *Philosophy and Public Affairs* 13:4 (1984): 353

analysed physician autonomy in terms of of the *ideal advocate*.[13] He rejected this approach and prefers that it be placed in the wider context of justice, opportunity costs and a *closed* system. Furthermore, he resists the view that health care is a commodity or service. For him health care is a social good of special moral importance.[14]

The failure of the American health care system is embedded in the fact that the system is not sufficiently *framed* or *closed* and governed by basic principles of justice:

> In our system, saying 'no' to beneficial treatments or technologies carries no assurance we are saying 'yes' to even more beneficial ones. Our system is not closed; the opportunity costs of a treatment or technology are not kept internal to it. Just as important, the system as a whole is not governed by a principle of distributive justice, appeal to which is made in decisions about disseminating technologies. And our system is not closed under constraints of justice.[15]

Daniels isolates in his writings a number of other factors influencing the shape of U.S. health care. Attention is more readily given to *identified* patients than to *statistical* patients.[16] This is well illustrated by the way the community responds to denial of high-tech procedures for individuals in tragic situations. Acute care medicine with all its glamour and scientific aura has resulted in the neglect of chronic illness. A system that is primarily employment-based and favours private insurance has overlooked long-term illness and its appropriate care.[17] Because of these realities Daniels urges breaking the link between employment and medical insurance. Should this occur the understanding of medical insurance as risk management will give way to ways that ensure access to necessary health care services.

4.1.1.3 Rationing Health Care

An evolution is observable in Norman Daniels' published work. He has maintained his focus on doing practical ethics and developing public policy. More recently he shows a willingness to be more concrete and specific in his philosophical reflection,

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13 N. Daniels, "The Ideal Advocate and Limited Resources", *Theoretical Medicine* 8:11 (1987): 69-80.

14 N. Daniels, "Why Saying No to Patients in the United States is so Hard. Cost Containment, Justice, and Provider Autonomy", *The New England Journal of Medicine* 314:21 (1986): 1381; see also N. Daniels, *Am I My Parents' Keeper? An Essay on Justice Between the Young and the Old*, (New York: Oxford University Press, 1988), 140-143

15 Daniels, *Am I My Parents' Keeper?*, 147

16 Daniels, "Comment..." *Transplantation Proceedings*, 3424

17 N. Daniels, "Chronic Illness: Not-So-Passive Injustice?", *The Journal of Clinical Ethics* 2:3 (1991): 160.

exploring the practical and complex issue of rationing health care. He views this task as "a prolegomenon to serious work in 'applied ethics'."[18]

Daniels' effort to understand what it means to ration fairly commenced with the observation that when rationing takes place (1) the goods we often must provide, such as legal services, health care and educational benefits, are not divisible without loss of benefit, as in the case of money; (2) when we ration we deny benefits to some individuals who can plausibly claim they are owed them in principle; (3) the general distributive principles appealed to by claimants as well as by those who do the rationing do not by themselves provide adequate reasons for choosing among claimants, since these principles are too schematic; (4) even the best work in the general theory of justice has not squarely faced the problems raised by the indeterminacy of distributive principles.[19] In his effort to specify the implications of the act of rationing Daniels focuses on four problem areas yet to be resolved in the Oregon experiment: (1) *The fair chances/best outcomes problem*: which of several equally needy individuals should get a scarce resource, such as a heart transplant? (2) *The priorities problem*: the unsolved priorities problem not only affects a methodology that ranks by net benefit or by net quality adjusted life years (QALY's), it also impinges on cost/benefit and cost/effectiveness rankings, the willingness to pay methodology and the aggregation problem. (3) *The aggregation problem*: the complex debate about whether "numbers count" has a bearing on the rationing problem.[20] (4) *The democracy problem:* should the democratic process be thought of

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[18] N. Daniels, "Rationing Fairly: Programmatic Considerations", *Bioethics* 7:2-3 (1993): 232. In a critique of a medical ethics text by Emanuel Daniels makes a similar point: "The incompleteness Emanuel ascribes to the equal opportunity account, and to liberalism more generally, derives from a general incompleteness of distributive theories that do not incorporate a theory of rationing. Even if we adopt a particular conception of the good that favored a particular rationing scheme, we would still face the problem of incomplete determination I sketch here. Communitarians in general can no more solve the problem of rationing by direct appeal to their values than adherents to liberal principles." in N. Daniels, "Liberalism and Medical Ethics", *The Hastings Center Report* 22:6 (1992): 42-43. The claim regarding communitarians would seem to be incorrect. It assumes that the liberal society will never become a *closed* or *framed* society. Communitarians propose a number of ways that *close* the social framework for the *common good*

[19] Daniels, "Rationing Fairly...," *Bioethics*, 224. He concludes these observations with the interesting comment: "If however, there are substantive principles governing rationing, then the theory of justice is incomplete in a way we have not noticed. This point cuts across the debates between proponents of 'local justice'...and 'global justice'...and between liberalism and communitarianism..."(*ibid.*, 225)

[20] "Kamm shows that we are not straightforward aggregators of all benefits and that our moral views are both complex and difficult to explicate in terms of well-ordered principles. These views are not compatible with the straightforward aggregation (sum ranking) that is presupposed by the dominant methodologies derived from welfare economics. Yet we do permit, indeed require, some forms of aggregation. Our philosophical task is to specify which principles governing aggregation have the strongest justification." in "Rationing Fairly...," *Bioethics*, 229-230

as a matter of pure procedural justice or should it be considered an imperfect form of procedural justice? If the latter then it is one that can be corrected by appeal to some prior notion as to what constitutes a fair outcome of rationing.[21]

4.1.2 Health Care

Daniels analysis of health care developed within the debates surrounding contemporary U.S. health care.[22] His concern is with macro-level decision making that focuses on the "scope and design of *basic health-care institutions*, the central institutions and social practices which form a health care system."[23]

The polarisation of ideas and widespread conflicts about the nature of health care in U.S. society provoked Daniels to ask a basic question: "Is health care special?"[24]:

> Is it a social good that we should distinguish from other goods, say video recorders, because of its special importance? Also, does that moral importance mean that there are social obligations to distribute it in ways that might not coincide with the results of market distribution? I believe the answer to all these questions is 'yes'.[25]

In addressing the specialness of health care Daniels argues that what is needed is a theory of health care needs. This, he suggests, will satisfactorily indicate why health care is special and why it should be treated differently from other social goods. It will also provide a basis for distinguishing what is of greater or lesser importance among the many kinds of things health care does for us. Central to his approach are the following assumptions: "If we can assume (1) that there is some scarcity of health-care resources, and (2) that we cannot or should not rely just on market mechanisms

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21 Daniels, "Rationing Fairly...," *Bioethics*, 225-232

22 Daniels' *Just Health Care* is the basis of this section. Daniels developed his thought in a number of articles published in the period before the book. These were worked into *Just Health Care*.

23 "Macro decisions determine (1) what kinds of health-care services will exist in society, (2) who will get them and on what basis, (3) who will deliver them, (4) how the burdens of financing them will be distributed, and (5) how the power and control of these services will be distributed." Daniels, *Just Health Care*, 2

24 Daniels uses this question as shorthand for a groups of questions about the nature of health care as a social good, viz.: "What explains this special importance or urgency we attribute to health care? Why should preferences for health care be treated differently from other kinds of preferences? Is there a function or effect of health care which explains the importance we attribute to it? Can we explain our belief that some kinds of health care are more important than others? Does the explanation for the special importance of health care show the relationship between health care and other, general kinds of social goods which are the subject matter of general theories of distributive justice?" Daniels, *Just Health Care*, 17

25 Daniels, "A Lifespan..." in *Aging and Ethics*, 234

to allocate these resources, then we need such a theory to guide macro decisions about priorities among health-care needs."[26]

Needs would appear a difficult foundation for the development of a comprehensive theory of just distribution of health care services. Daniels confronts this difficulty.[27] He acknowledges that the concept of needs is expansive and that frequently needs are reduced to the question as to the importance or urgency of preferences or wants in general. Obviously not all preferences are on a par. Some are more important than others. This also applies to our needs. And so, he writes:

> [the] philosophical task will be to characterize the relevant categories of needs in a way that *explains* two central properties they have. First, they are *objectively ascribable*. We can ascribe them to someone even if he does not realize he has them or even if he denies he does because his preferences run contrary to his needs. Second, . . . these needs are *objectively important*: we attach a special weight to claims based on them in a variety of moral contexts. Our task is to characterize the class of things we need which has these properties and to do so in a way that explains their importance.[28]

Daniels distinguishes different sorts of needs. *Course-of-life-needs* differ from *adventitious needs*. Where the former are lacking their deficiency "endangers the normal functioning of the subject of need *considered as a member of a natural species*."[29] Such needs are, therefore, necessary to maintain *species-typical normal functioning*. Impairments of normal species functioning reduce the range of opportunity open to the individual in which he may construct his plan of life or conception of the good.[30] For Daniels:

> the *normal opportunity range* for a given society is the array of life plans reasonable persons in it are likely to construct for themselves. An individual's fair share of the normal opportunity range is the array of life plans he or she may reasonably choose, given his or her talents and skills.[31]

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26 Daniels, *Just Health Care*, 19

27 Daniels, *Just Health Care*, 23

28 Daniels, *Just Health Care*, 25-26

29 Daniels, *Just Health Care*, 26

30 Daniels, *Just Health Care*, 27. "We may think of a life plan as a long-term plan in which an individual schedules activities so that he can harmoniously satisfy his desires. The good for an individual is defined by reference to this plan and the choice of goals, projects, and means for achieving them it contains (Rawls 1971:92ff.). We can consider a person happy when he is successful in carrying out his plan. The notion of a plan of life thus has some similarity to the utilitarian's notion of a utility function, but it directly implies a plan to satisfy desires over the long term." (*ibid.*, 27-28). The concept of "plan of life" comes from J.S. Mill and has been given prominence in recent times by John Rawls. Cf. *Am I My Parents' Keeper?*, 35

31 Daniels, "A Lifespan..." in *Aging and Ethics*, 235

Using a biomedical understanding of health as the absence of disease, Daniels understands disease to be a deviation from the natural functional organisation of a typical member of a species.[32] "Health care needs are those things we need in order to maintain, restore or provide functional equivalents (where possible) to normal species functioning."[33] But why should normal species-functioning be so significant in the area of health needs? The answer to this is to be found in the way Daniels connects *species-typical functioning*, *opportunity* and the notion of the *normal opportunity range*. He concludes that:

> impairment of normal functioning through disease and disability restricts an individual's opportunity *relative to that portion of the normal range his skills and talents would have made available to him were he healthy*. If an individual's fair share of the normal range is the array of life plans he may reasonably choose, given his talens and skills, then disease and disability shrinks his share from what is fair.[34]

This way of thinking enables Daniels to claim "impairment of the normal opportunity range as a fairly crude measure of the relative importance of health-care needs at the macro level."[35]

At this point it is appropriate to note that Daniels rejects the appeal of the right to health care as a starting point for analysing distributive justice and health care services. He does so on two grounds. First, he considers that:

> we are justified in claiming a right to health care only if it can be harvested from an acceptable, general theory of distributive justice, or, more particularly, from a theory of justice for health care. Such a theory would tell us which kinds of right claims are legitimately viewed as rights.[36]

As noted earlier it is by means of a more basic theory of health care needs and a systematic theory of distributive justice that Daniels intends to address the problems of macro decision making and policy development in the health care system of the U.S.A. Second, he considers *right to health care* to be an ambiguous notion. A right may be positive or negative. Furthermore, are we speaking about a *right to health* or a *right to health care*? If the notion of equality is introduced into the concept are we speaking about an *equal right to health* or a *right to equal health*. Claimants of the right to health may infer that certain individuals or groups or society as a whole are obliged to perform certain actions which promote or maintain good health and are

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32 Daniels, *Just Health Care*, 29

33 Daniels, *Just Health Care*, 32.

34 Daniels, *Just Health Care*, 33-34

35 Daniels, *Just Health Care*, 35

36 Daniels, *Just Health Care*, 5

obliged to refrain from actions which interfere with it. This broadens the claim to include a wide range of actions that affect health, such as the protection of the environment. Daniels agrees with Charles Fried that "a right claim to equal *health* is best construed as a demand for equality of access or entitlement to health *services* - where these may include preventive and environmental measures".[37]

Another distinction of importance often overlooked is that those who claim a right to health care intend only "a system-relative claim to health care: whatever health-care services are available to any within the given health-care system should be accessible to all."[38] This is different from a right claim that requires some specifiable range of health care services be made available to all (and perhaps that any additional services be made available to some only if they are availabe to all). This may require the expansion or contraction of existing health care services not only in terms of who is treated but also in terms of what services are offered.

In the light of the above clarifications Daniels concludes that:

> Claiming a 'right to health care' reduces to a composite of other rights and claims, among them: (1) society has the duty to its members to allocate an adequate share of its total resources to health-related needs, such as the protection of the environment and the provision of medical services; (2) society has the duty to provide a just allocation of different types of health services, taking into account the competing claims of different types of health needs; (3) each person is entitled to a fair share of such services, where a 'fair share' includes an answer to the question, Who should pay for the services?[39]

4.1.3 Explanatory Framework

4.1.3.1 The Rawlsian Approach to Justice

John Rawls has proposed that society be held responsible for guaranteeing the individual a fair share of basic liberties, opportunity, and the all-purpose means, such as income and wealth, necessary for pursuing individual conceptions of the good. These Rawls designates as *primary social goods*. Individuals are responsible for choosing their own particular ends in such a way that they have a reasonable chance of satisfying them under just arrangements. It is these just arrangements that are supposed to guarantee individuals a reasonable share of basic or primary social goods. In Daniels' view these primary goods:

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37 Daniels, *Just Health Care*, 7

38 Daniels, *Just Health Care*, 7

39 Daniels, *Just Health Care*, 8

> constitute for Rawls the relevant, truncated scale of well-being *for purposes of justice* . . . The immediate object of justice is not, then, happiness or the satisfaction of desires, though just institutions provide individuals with an acceptable framework within which they may pursue happiness. But in this pursuit, individuals remain responsible for the choice of their ends, so there is no injustice in not providing them with means sufficient to reach extravagant ends.[40]

Liberal political philosophy has relied on what is essentially a *procedural* notion, namely equality of opportunity, to justify a system in which unequal outcomes are deemed morally acceptable. The first-world context of Rawls' justice theory gives considerable weight to jobs and offices. These reward individuals in society. Justice-as-fairness demands that competition in securing these valued positions must be fair. Race, religion, ethnic origin and sex are judged to be morally irrelevant when comparing individuals. Rather, it is the talents and skills relevant to the positions being sought that should determine who is selected and ultimately rewarded. Rawls thus gives high priority to the fair equality of opportunity principle.[41] It is this notion of fair equality of opportunity that Daniels has appropriated:

> I urge the fair equality of opportunity principle as an appropriate principle to govern macro decisions about the design of our health-care system. Such a principle defines, from the perspective of justice, what the moral *function* of the health-care system must be - to help guarantee fair equality of opportunity. This is the fundamental insight underlying the approach developed.[42]

4.1.3.2 Extending Rawls' Theory to Health Care

Daniels has argued that the most promising strategy for extending Rawlsian justice-as-fairness to health care lies in including health care institutions and practices among the basic institutions involved in providing for fair equality of opportunity.[43] Because meeting health care needs has an important effect on the distribution of opportunity, health care institutions are regulated by the fair equality of opportunity principle. Health care institutions help provide the framework of liberties and

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[40] Daniels, *Just Health Care*, 38

[41] Daniels notes that "fair equality of opportunity cannot be traded away to provide material gains for individuals: fair equality of opportunity is given *lexical* or *lexicographical priority* over the principle which permits inequalities in other social goods. When a principle has lexical priority in a series of principles, it must be satisfied first, before we can move on to satisfy further principles." Daniels, *Just Health Care*, 40

[42] Daniels, *Just Health Care*, 41

[43] In his early thinking about Rawls Daniels discusses four strategies for applying justice as fairness to health care. See his "Rights to Health Care and Distributive Justice: Programmatic Worries", *Journal of Medicine and Philosophy* 4:2 (1979): 182-190

opportunities within which individuals can use their fair income shares to pursue their own conceptions of the good.[44]

For Rawls equality of opportunity is strategically important. It is not merely sufficient to remove formal or legal barriers to persons seeking jobs. These are barriers based on race, class, ethnic origin or sex. Positive steps must also be taken to enhance the opportunity of those disadvantaged by social factors such as family background or genetic history. These advantages or disadvantages from the *natural lottery* are morally arbitrary and undeserved. Permitting them to determine individual opportunity and the rewards of life is to confer arbitrariness on outcomes which is unfair. For this reason "if it is important to use resources to counter the advantages in opportunity some get in the natural lottery, it is equally important to use resources to counter the natural disadvantages induced by disease."[45] The combination of unequal distribution and great strategic importance of opportunity places health needs in a separate category to basic needs such as food and shelter. These people are expected to purchase from their fair shares.[46]

Daniels has modified Rawls' discussion of the hypothetical situation where the contractors, in the original position, make choices behind a veil of ignorance. In selecting principles to govern health care resource allocation decisions the contractors must operate under a thinner veil than that proposed by Rawls. They must be aware, Daniels argues, of certain features of their society such as resource limitations.[47]

Four layers or levels of the health care system are judged important for ensuring fair equality of opportunity. These will ensure normal, fully functioning persons over a complete lifespan.[48] The four levels are: (1) preventive health, (2) personal, medical, rehabilitative services, (3) medical and social support for the chronically ill and disabled frail elderly, (4) terminal care, care for the mentally and physically disabled.[49]

Daniels' development and application of the Rawlsian justice-as-fairness approach acknowledges its conditional and incomplete character. He accepts that the concern

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44 Daniels, *Just Health Care*, 45

45 Daniels, *Just Health Care*, 46

46 Cf. Doyal and Gough, *A Theory of Human Need*, 186

47 Daniels, *Just Health Care*, 47

48 Daniels deals in some detail with critics of the fair equality of opportunity principle. Cf. Daniels, *Just Health Care*, 49-55

49 Daniels, *Just Health Care*, 47-48

with opportunity is not the only factor that should bear on the design of health care systems. Other social goods may make demands on health care services. Daniels' primary focus has been on the social obligation to maintain and restore health. He has ignored individual responsibility for health care.[50]

The exposition of Norman Daniels' thinking thus far has indicated his sources and how he has used them. Two further areas require consideration to show how he develops the fair equality of opportunity principle. *Equity of access* to health care services is his first concern. Its *locus* of application is the whole of a human life - Daniels' *prudential lifespan account.*

4.1.3.3 Equity of Access to Health Care

The fair equality of opportunity account proposed by Daniels has implications for wider policy discussions about access to health care services. He notes that the literature on equity of access is complex and confusing. Indeed, there is no consensus as to what counts as equitable access. There are three central reasons for divergence on this question. First, access is itself a complicated notion, a composite of many factors. Second, health-care services are non-homogeneous. Third, and perhaps more fundamentally, divergence on what counts as equitable access derives from divergence on more basic moral questions, specifically questions of distributive justice.[51]

Daniels uses the term *equity* in a broad sense roughly equivalent to *distributively fair or just*. Bioethical literature frequently discusses equity in terms of equal access. But in the notion of equal access:

> we must already have made various decisions about what considerations ought to count in judging when access is equal. These decisions reflect our purpose or interest in making the judgment about equality, and some of these discriminations are themselves moral. So moral considerations are already embedded in the specification of equality and are not held at bay until we get to decisions about equity.[52]

In normal parlance equal access indicates a negative criterion. Constraints on access to health services such as financial and geographical factors should exercise little or no influence in determining whether people get them. "Thus there is agreement about

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50 Daniels, *Just Health Care*, 55-56

51 Daniels, *Just Health Care*, 59

52 Daniels, *Just Health Care*, 61. "I allow my notion of *equality of access* to be determined, in part, by *prior judgments about equity of access*.(*ibid.*, 62)

what to call equal access only because there is agreement not to accept a particular kind of inequality."[53]

Daniels indicates the weaknesses inherent in three theories of equal access to health care services. The first approach understands equity of access as a function of need. The second concentrates on the processes for obtaining health care while the third takes a market approach. In this last rationale access to health care is seen to be equitable if there are no financial barriers or supply anomalies that prevent access to a reasonable or decent basic minimum of health care services.[54] All of these theories have had wide discussion in the bioethical literature of health care allocation.

Daniels considers that his fair equality of opportunity account adequately addresses many of the weaknesses shown to exist in the above three theories. He makes four strong claims. First, his account is compatible with, though it does not imply, a multi-tiered health care system. More importantly, however, the basic tier of health care services must "include *health-care services that meet health-care needs, or at least important health-care needs - as judged by their impact on the normal opportunity range.*"[55] Second, the fair equality of opportunity account provides a principled way of characterising health care services that fall in the socially guaranteed tier. They are the services needed to maintain, restore, or compensate for the loss of normal species-typical functioning. In turn, normal functioning contributes substantially to defining the share of the normal opportunity range open to individuals.[56] Third, no matter what way the upper tiers of the health care system are to be financed there should be no obstacles whether financial, racial or geographical, to access to the basic tier. Finally, the fair equality of opportunity account has nothing to say about health care facilities which have no effect on health status and is likewise silent on equity of access requirements to the upper tiers of the health care system.[57]

4.1.3.4 The Prudential Lifespan Account

The previous pages have indicated the central role played by the fair equality of opportunity principle in Daniels' thinking. The second axis of his approach he calls

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[53] Daniels, *Just Health Care*, 62-63

[54] Daniels, *Just Health Care*, 63-78. See also N. Daniels, "Equity of Access to Health Care: Some Conceptual and Ethical Issues", *Milbank Memorial Fund Quarterly/Health and Society* 60:1 (1982): 51-81.

[55] Daniels, *Just Health Care*, 79

[56] Daniels, *Just Health Care*, 79

[57] Daniels, *Just Health Care*, 80-81

the prudential lifespan account. His proposal is developed in the context of an analysis of conflict between the old and young in society:

> Justice between age groups . . . is a problem best solved if we stop thinking of the old and the young as distinct groups. We age. The young become old. As we age we pass through institutions that affect our well-being at each stage of life, from infancy to very old age. The lifespan approach is based on the suggestion that we must replace the problem of finding a just distribution between 'us' and 'them' - between groups - with the problem of finding a prudent allocation of resources for each state of our lives. On the lifespan approach, each stage of life stands as a proxy for an age group. To determine what is fair or just between age groups we must find out when institutions treat each stage of life prudently.[58]

Central to this lifespan perspective is an understanding of the savings that occur over a whole lifetime:

> (A)s we age, we pass through institutions that redistribute wealth and income in a way that performs a *savings* function. The observation is trivial with regard to income support institutions, such as the Social Security system. It is not often noticed that our health care system does the same thing. When we reach age 65, we consume health care resources at about 3.5 times the rate (in dollars) that we do prior to age 65. However, we pay, as working people, a combined health care insurance premium - through private premiums, through employee contributions, and through Social Security taxes - that covers not just our actuarially fair costs, but the costs of the elderly and of children as well. If this system continues as we age, others will pay 'inflated premiums' that will cover our higher costs when we are elderly. In effect, the system allows us to defer the use of resources from one stage of our lives to a later one. It 'saves' health care for our old age - when we need more of it.[59]

The above two quotations from Daniels provide the bare bones of his prudential lifespan account. In order to provide a clear picture of his account it will be necessary to refer to five related issues present in his writings.

The first question arises from possible inequalities in the way different age groups are dealt with throughout the lifespan. Daniels argues that differential treatment by race or sex always generates inequalities between persons. However, age is different. The banal fact is that all people grow older, but they do not change their race or sex. If the young are treated one way and the old another, then over time, each person is treated in both ways. The advantages (or disadvantages) of *consistent* differential treatment by age will equalise over time. An institution that treats the young and the old differently will, over time, still treat people equally. Whereas differential treatment by race and sex always generates inequalities between persons, differential

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[58] Daniels, *Am I My Parents' Keeper?*, 18

[59] Daniels, "A Lifespan..." in *Aging and Ethics*, 236-237

treatment by age does not necessarily generate inequalities.[60] In fact, it may be equal treatment of persons over time even though it entails unequal treatment of age groups on each occasion and at each moment. The fundamental question for Daniels is: Which unequal treatments of age groups are just or fair?[61]

Analysis of the lifespan account leads Daniels to explore the financial aspects of aging. The first of these is the role of savings in contemporary society. Daniels transfers the function of savings in society, especially that of pension plans and taxation, to the health care environment. If society is community rated as one risk pool, in a way similar to the way insurance functions, it results in the old paying less and getting more, while the young pay more and get less. The prudential lifespan account rejects the view that justice involves distinct groups in competition with one another:

> Rather, we must see that each group *represents* a stage of our lives. We must view the prudent allocation of resources through the stages of life as our guide to justice between groups.[62]

The implications of this insight for distributive justice are significant. From the perspective of stable institutions operating over time, unequal treatment of people by age is a kind of budgeting within a life.[63]

The second financial aspect Daniels studies is that of income support.[64] This gives rise to an important question. "How would it be prudent, from the perspective of our hypothetical deliberators, to allocate income over the lifespan?"[65] Daniels adopts the classical theory of rational prudence which gives equal concern to all parts of the deliberator's life. The Difference Principle proposed by John Rawls to explain income inequalities between persons is judged by Daniels to be deficient.[66] He argues for a prudent course of action which allocates resources in such a way that income would remain roughly equal over the lifespan. He calls this the *Income (or Standard of Living) Preservation Principle* which:

> ensures that institutions facilitate income transfers over the lifespan in such a way that the individual has available to himself, at each stage of life, an adequate income to pursue whatever plan of life he may have at

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60 Daniels, *Am I My Parents' Keeper?*, 41

61 Daniels, *Am I My Parents' Keeper?*, 42

62 Daniels, *Am I My Parents' Keeper?*, 45

63 Daniels, *Am I My Parents' Keeper?*, 46. The theory assumes the *stability* of institutions. This assumption is evidence of his ideal theory focus on justice.

64 Daniels, *Am I My Parents' Keeper?*, 117-138

65 Daniels, *Am I My Parents' Keeper?*, 120

66 Daniels, *Am I My Parents' Keeper?*, 120-121

> that stage of life. Of course, 'adequate' is here relative to his lifetime fair income share.[67]

This approach to income support leads Daniels into an analysis of the U.S. social security system. This need not delay us here. Obviously such a line of argument must be sustained if Daniels is to adequately explain the concrete demands of distributive justice as they pertain to the health care system in the U.S.A. His exploration of savings and income issues well illustrates his credentials in practical ethics.

The fourth significant element related to Daniels' prudential lifespan account is to be found in the requirement to frame the age-group problem.[68] He argues that we must:

> restrict or *frame* the age-group problem by drawing on our prior answers to more basic questions about distributive justice. We must first know, for example, what principles of distributive justice govern income or health-care distribution in general before we can determine how income or health care should be distributed between age groups... this would be like trying to budget health care over the lifespan without knowing how much we have to budget.[69]

Failure to *close* or *frame* the health care system deprives U.S. health care of the capacity to rationalise its services and confront the imperative of limited resources. Daniels repeatedly affirms this point in his writings.

Any consideration of the prudential lifespan account would be incomplete without reference to Daniels' understanding of prudence.[70] As mentioned already the theory of individual rationality which underpins much liberal political theory presumes that the individual is concerned with his or her well-being over a lifetime. Well-being is therefore assessed in a way that is neutral with regard to time. Daniels argues that "a *time-neutral* concern for well-being over the lifespan is one of the demands of prudence itself."[71]

Against a background of Rawlsian theory Daniels attends to a number of related issues.[72] The neutrality of prudential decision-making requires that the contractors in

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67 Daniels, *Am I My Parents' Keeper?*, 121

68 Elsewhere Daniels speaks of a *closed* system

69 Daniels, *Am I My Parents' Keeper?*, 48

70 Cf. Daniels, *Am I My Parents' Keeper?*, 52-65

71 Daniels, *Am I My Parents' Keeper?*, 57

72 "Rawls believes that constraints on choice, such as the 'thick veil of ignorance' he imposes and the 'thin theory of the good', that is, his index of primary social goods, are fair to persons because they reflect this basic ideal about the nature of moral agents. It is reasonable for us to abide by the hypothetical contract because, presumably, we share these background ideals about persons and the role of morality in society. At least within the liberal democratic tradition, these are a shared ideal." Daniels, *Am I My Parents' Keeper?*, 62

the original prosition keep their options open and this for two reasons. First, it means assuring at each stage of life that the individual has an adequate chance of pursuing whatever his or her lifeplan is. Second, it acknowledges that conceptions of what is good are *incommensurable* in the sense that there is no perspective from which they may be ranked neutrally.

In the light of this Daniels proposes a more modest notion of prudence.[73] He argues that prudence itself (under the standard assumptions) requires that individuals respect their own changes in their conception of what is good at each stage of life. Their concern for their own lifetime well-being will require them to abstract from full information in order to be neutral about each stage of their lives, at least when they are considering the design of institutions that affect them over the whole lifespan:

> My prudent deliberators, even though they use Rawlsian restrictions on prudential reasoning, cannot attempt to solve problems of justice which cross the boundaries between persons. My prudent deliberators are concerned only with the *framed* problem of justice between age groups.[74]

How then do prudent deliberators design a health care system? Daniels suggests two steps.[75] First, prudent deliberators must attend to the disease/age profile of their society. The health care system must be responsive to the types and frequency of diseases and disabilities that emerge at different points in the lifespan. Second, the age profile of the society and projected demographic changes must also be calculated resulting in attention being given to the long-term care needs of the elderly. Medical services, personal care, social support services and the needs of family care givers are likewise important factors in this context. The relative importance of other categories of health care services such as the role of preventive services must also be borne in mind. Prudent deliberators, therefore, in Daniels' prudential lifespan account, make decisions that "reflect the ways in which services will have an impact on the age-relative normal opportunity range, which is their crude measure of the importance of meeting different health-care needs."[76]

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[73] "My use of Rawlsian devices does not depend on an appeal to his robust Kantian account of the nature of persons or to his claims that the choice situation is procedurally fair to such persons." Daniels, *Am I My Parents' Keeper?*, 62

[74] Daniels, *Am I My Parents' Keeper?*, 62-63

[75] Daniels, *Am I My Parents' Keeper?*, 76-81

[76] Daniels, *Am I My Parents' Keeper?*, 80

4.2 THE CONTRIBUTION OF DANIEL CALLAHAN

4.2.1 Callahan's Philosophical Agenda

4.2.1.1 Reflecting Bioethically

In a series of articles in the early 1980s Daniel Callahan sketched a number of elements he considered significant in the newly developing discipline of biomedical ethics.[77] He had become by that time a leading figure in this new discipline. As co-founder of the Hastings Center in 1969 he was at the forefront of developments in the United States and has continued to the present time as an important contributor in the field.

In his Shattuck Lecture of 1980 Callahan held that biomedical ethics was entering a new phase which would require a rethink of its role, methodology and its relation to other disciplines and institutions. Rapid changes in technology were challenging the received values and moral principles:

> The moral vision that gave coherence and guidance in the past under one set of social conditions appears threatened by new and disruptive conditions. And what could be newer and more disruptive than biomedically induced chances in mankind's ancient struggle with illness and death?[78]

He suggested that "(w)hen questions of ethics are widely and heatedly discussed, it is a good rule of thumb to assume that some larger cultural process is taking place, of which a concern with morality is only one symptom."[79] The range of problems resulting from biomedical developments has stimulated questioning of the fundamental goals and assumptions of medicine. Callahan has returned repeatedly to this insight. In fact it has shaped much of his work since 1980.

Callahan noted the impoverishment and inadequacy of much Anglo-American philosophy during the 1940s and 1950s and the renewal of interest in practical ethics during the 1970s. Paralleling these developments there occurred an increasingly strong interaction between ethics, law and regulation. Callahan viewed this as an

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[77] See his earlier effort in medical ethics: D. Callahan, *Abortion: Law, Choice and Morality*, (New York: Macmillan, 1972)

[78] D. Callahan, "Shattuck Lecture - Contemporary Biomedical Ethics", *The New England Journal of Medicine* 302:22 (1980): 1229

[79] Callahan, "Shattuck Lecture...," *The New England Journal of Medicine*, 1229

emphasis on the individual at the cost of the wider community. This reinforced the individualism of American society and excluded considerations of *the public interest* or the *common good.*[80]

Callahan has observed that during the 1970s consensus was reached on a large number of issues but without any agreement on theoretical principles and foundations[81]:

> What I want now to contend is that the next round of ethical problems may be far more resistant to practical consensus than those that captured attention during the past decade. They will be resistant precisely because they will much more directly force a grappling with theoretical issues of morality and medicine, and they will, more than ever, reveal the shortcomings of the language of *rights*, of individualism, and of merely procedural solutions to problems of deep principle.[82]

Early bioethical literature focused on the moral dilemmas confronting the doctor viewed in isolation. Callahan was aware of social and policy decisions that would raise complex moral issues:

> It will force biomedical ethics to move into the mainstream of political and social theory, beyond the model of individual decision maker, and into the thicket of important vested and legitimate private and group interests. The language of *rights* is not likely to be up to that task, unless there is a better language for the rights of an entire group, nor is a focus on the intricacy of individual decision making likely to be of much help.[83]

In 1981 Callahan continued his analysis of the American ethos by outlining what he called a *morality of affluent times*. This moral perspective "has stressed the transcendence of the individual over the community, the need to tolerate all moral viewpoints, the autonomy of the self as the highest human good, and the voluntary, informed consent contract as the model of human relationships."[84] In opposition to this moral scenario Callahan proposed a *morality of hard times*. Its focus is self-sacrifice and altruism, a sense of community and the common good. It demands restraint in blaming others for misfortune and a broad sense of duty to others, particularly those out of sight. This leads Callahan to suggest that contemporary (first world) cultures have systematically avoided communal goals, have replaced ultimate ends with procedural safeguards, have banished the fundamental questions of human

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80 Callahan, "Shattuck Lecture...," *The New England Journal of Medicine*, 1230

81 Cf. D. Callahan, "Morality and Contemporary Culture: The President's Commission and Beyond", *Cardozo Law Review* 6 (1984): 347-55. Note a similar point made by Daniels in his last article on health care reform and by Callahan regarding the President's Commission

82 Callahan, "Shattuck Lecture...," *The New England Journal of Medicine*, 1231

83 Callahan, "Shattuck Lecture...," *The New England Journal of Medicine*, 1233

84 D. Callahan, "Minimalist Ethics", *The Hastings Center Report* 11 (1981): 19

meaning to the private self and have sought to make the morally autonomous agent the cultural ideal.[85] He names the ethic of liberal society a *minimalist ethic*. Simply put "*[o]ne may morally act in any way one chooses so far as one does not do harm to others*" [his emphasis]. The pervasiveness of this ethic in today's society has important consequences.[86]

In the following year Callahan further considered the landscape of moral philosophy in an article on tradition and the moral life. He concluded that the moral and political experiments of the 1960s and 1970s had failed.[87] His concluding analysis gave some inkling of the direction he was subsequently to take in later writings. He accepted MacIntyre's point that a moral culture centered on rules is inferior to one built on virtue. However, he modified this position by suggesting that the existence of more rules may well be a propaedeutic to developing virtue within society. The traditions that count are those shaped by culture and those sensitive to forces which are both local and universal. Callahan's notion of tradition, therefore, is important:

> Traditions might be understood in two senses. One sense is that of a general model that ought to obtain between the various units of society, linking coherently the individual, the family, mediating institutions, the state, and an ultimate human *telos*. The picture is one of a desired gestalt, thin on specific contents, but strong on structural relationships. The other sense of tradition specifies particular values and goods - freedom, justice, the family, for example - but provides no picture of the whole. . . A successful and valid tradition, I suggest, is one that can combine both senses of tradition. In its original setting, a powerful tradition will discern how the larger whole hangs together, and will unceasingly want a larger whole, one linking the trivial and the transcendent, from etiquette in daily life to shared cosmic meaning. It will combine a set of specific and commonly interpreted values into a coherent pattern. That pattern will be discernible whether one begins by examining a particular value to see its place among others (from the bottom up, so to speak), or from the top down, by beginning with its

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85 Callahan, "Minimalist Ethics", *The Hastings Center Report*, 20

86 Callahan outlines seven consequences. "In some quarters, a minimalist ethic has gone a step further, to a de-listing of many behavioral choices as moral problems at all. Thus abortion becomes a 'religious' rather than a moral issue, and it is well known that all religious issues are private, a-rational, and idiosyncratic; questions of sex, and most recently homosexuality, become matters of 'alternative life styles' or 'sexual preferences'...". Callahan, "Minimalist Ethics", *The Hastings Center Report*, 20-21

87 These he portrays as the antinomian situation ethics of the 1960s and the reductionism of sociobiology in the 1970s. "The thinness of the moral inventions of the recent past lay not just in their content, but no less in their naive belief that a fresh ethic could be constructed *ex nihilo*. More moderate attempts to give public ethics a tougher backbone - whether in the form of revised versions of utilitarianism or more rigorous theories of rights and entitlements - have also faltered. They show too many signs of originating in the potting shed of moral theory rather than springing from the wilder terrain of the lived moral life." Callahan, D. "Tradition and the Moral Life." *The Hastings Center Report* 12:6 (1982): 23-30 at p.23.

> largest notion of human purpose and meaning. The two paths will nicely converge.[88]

These two strands do not, in fact, converge in U.S. society. Rather, there exists a pluralism of traditions.[89]

Historically, biomedical ethics has applied to medical issues the norms, principles, methodologies or modes of thinking drawn from wider cultural sources such as religion, philosophy and law.[90] Biomedical developments in more recent times are so changing human living that these changes may be forcing a reevaluation of many traditional values.[91] Callahan suggests four specific areas where this is the case: the doctor-patient relationship, the allocation of health resources, sanctity of life and quality of life, and interventions into nature. Callahan considers that each of these four examples has pushed us into unfamiliar moral territory. The major ethical traditions are inadequate for resolving the moral problems before us.[92] Hence the need to fashion a moral consensus in contemporary society.[93] "That consensus must be sufficiently strong to provide medicine with a moral culture that is coherent, perspicuous, and human, and yet sufficiently flexible to permit legitimate variations in moral cultural values."[94] This insight would seem to influence much of Callahan's later writings. It has provoked him to work at developing public policy for health care based on consensus. He has sketched its components as follows:

> I believe that the most important parts of any institution are its moral values and traditions; that, indeed, without such values there can be no valid institutions. And that requires some core of agreement that bespeaks a set of animating ideals, some commonly understood and observed moral principles and rules, a shared commitment to certain

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88 D. Callahan, "Tradition and the Moral Life", *The Hastings Center Report* 12:6 (1982): 30

89 Callahan quotes Bruce Jennings' understanding of tradition with approval:"'Tradition provides a framework or matrix in which new actions take place and to which these actions may be assimilated; although it does not tell us what to do, it provides us with a way of making sense of what we are doing'" Callahan, "Tradition...," *The Hastings Center Report*, 30.

90 In D. Callahan, "The Waning of Old Ethical Models" in *Bioethics Today. A New Ethical Vision*, edited by J. W. Walters, (Loma Linda/Riverside, Ca.: Loma Linda University Press, 1988), 1-12, he argues that we are entering the third stage of medical ethics. The first stage is the Hippocratic ethic, the second stage extends from the mid-1960s to the end of the 1970s. The third stage unfolded in the 1980s.

91 Callahan, "Morality…," *Cardozo Law Review*, 347-55

92 Callahan names the rationalism of the Enlightenment tradition, theological, Marxist and collectivist traditions and liberal individualism. Callahan, "Morality…," *Cardozo Law Review*, 351-352

93 "we need a new mode of thinking to decide how we should make moral decisions, how we want to set standards, and how we are to understand progress. The truly important need is genuinely moral solutions to bioethical dilemmas and a way to tell good decisions from bad. This seems to me to be the main problem before us." in Callahan, "The Waning...," in *Bioethics Today*, 12

94 Callahan, "Morality…," *Cardozo Law Review*, 352

> character traits and virtues, and responsible procedures for handling conflicts, dilemmas and disputes. In medicine, where the sick put their very lives in the hands of others, a moral culture is particularly important. At the least, patients must understand the kind of institution to which they have committed their fragility and vulnerabilities; further, they must be able to trust that those who care for them share a morality they can respect. The idea of medical care as a kind of open city of morality - with no established values and a rampant individualism - would do little more than terrorize most patients; and their fears would not be unjustified.[95]

The consensus Callahan proposes must be relevant and new. Its purpose must be to chart a course between individualism and traditionalism, between the private and the public, between law and morality.

4.2.1.2 Technology

A fundamental attitude to technology pervades the entire *corpus* of Callahan's published works. He sees the dialectic between technology and culture as having long term implications:

> the advance of technology requires a set of affirmative cultural attitudes in the first place; and, in the second place, the technology once achieved brings some changes not only in the details of those sustaining attitudes but also in a host of other cultural attitudes and values, usually going well beyond anything envisioned in the first impulse to develop a particular set of technologies.[96]

Peter Steinfels, in an early critique of Callahan, correctly observed his tendency to place cultural attitudes "as the moving forces in history as though they were largely independent of social and economic institutions."[97] In health care Callahan has neglected the role health providers and socioeconomic institutional frameworks play in determining what individuals or society want. This criticism needs to be borne in mind in any critique of Callahan's work. It would seem to hold good for all his writings and perhaps explains some of the strong criticisms Callahan has received particularly when he proposed an age criterion for distributing health care. He purports to write as a philosopher but fails to confront some of the technical problems of health care delivery as Norman Daniels has attempted to do. It would appear that Callahan writes with a broadly humanistic preoccupation. Furthermore, his extensive published output gives evidence of his interests as a journalist. These

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[95] Callahan, "Morality...," *Cardozo Law Review*, 353

[96] D. Callahan, "Biomedical Progress and the Limits of Human Health", in *Ethics and Health Policy*, edited by R. M. Veatch and R. Branson, (Cambridge, Mass.: Ballinger Publishing Co., 1976), 158

[97] P. Steinfels, "The Right to Health Care and the Anxiety of Liberalism: A Reply to Daniel Callahan" in *Ethics and Health Policy*, edited by R. M. Veatch and R. Branson, (Cambridge, Mass.: Ballinger Publishing Co., 1976), 171.

two factors have contributed to a somewhat diffuse and varied body of published material. This has resulted in a significant misunderstanding of his work particularly when he proposed the age criterion for restricting health care services to the elderly. A number of critics failed to appreciate the broader context of his humanism and communitarian values.

Callahan's attitude to technology may be characterised as that of a techno-pessimist.[98] He has written passionately about the double tyranny arising with technological societies:

> [T]echnological societies impose both a *tyranny of survival* and a *tyranny of individualism.* They impose the former because, in times of stress, their extreme fragility (stemming from the high base of expectation they engender and the high degree of total control their complexity demands) is instantly and terrorizingly apparent, creating a natural environment for an obsessive fear of annihilation, i.e. a tyranny of survival. They impose the latter - monomaniacal individualism - because only the privatized life seems viable or endurable in the midst of a system which presents itself as impersonal and uncontrollable. Thus is intensified the tyranny of individualism, which demands that each person create his or her own world *ex nihilo*: self-direction, self-realization, self-fulfillment - self, self, self.[99]

In spite of this bleak vision of technology Callahan is realistic enough to accept that it is here to stay, that human beings have been technological from the beginning as builders, shapers and tool-makers. Hence the problems of technology are problems of degree. Callahan distinguishes five categories of technology: preservation, improvement, implementation, destruction and compensatory technologies.[100] This leads him directly to a consideration of *human needs* - one of the enduring issues in all his writings.

He considers it imperative to distinguish between true and false needs since technology seems to engender needs which might not otherwise exist and which appear not to have existed in earlier eras.[101] The simplest and most plausible explanation is that human beings have more needs and desires than any technology has yet met, and that the satisfaction of one need, far from completing man, makes possible attempts to satisfy still other needs:

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[98] Cf. M. Charlesworth, *Life, Death, Genes and Ethics: Biotechnology and Bioethics*, (Sydney: ABC Books, 1989), 24-31

[99] D. Callahan, *The Tyranny of Survival and Other Pathologies of Civilized Life*, (New York: Macmillan, 1973), 57-58

[100] He discusses these in some details in *The Tyranny of Survival*, 64-74

[101] This discussion depends on *The Tyranny of Survival*, 75-77

> Human beings have desires which are infinite, knowing no bounds of hope or aspiration. In practice, short of sheerly physiological criteria, there is no effective way of distinguishing between *needs* and *desires*. All desires may not represent needs, but all needs carry with them desires; and a strong enough desire will have all the psychological characteristics of needs. Who is ever completeley satisfied in all things, and for how long? Technology is a gamble that infinite desires can be satisfied by finite means.[102]

Callahan doubts that we can speak of *false needs*. Rather it is better to speak of the false satisfaction of real needs.[103] He offers two criteria for discerning when real needs are being falsely met. A real need will be falsely satisfied when (1) the continuing existence of the need, not actually satisfied at all, is obscured or hidden by the immediate pleasures, or surcease from pain, produced by a technological artifice; and (2) when, despite any confirmatory evidence, technology is understood to hold out the hope that, given enough time, it will be able to satisfy all needs.[104] The second criterion plays a significant role in Callahan's conservative view of medical science and technology.[105] For him technology "will not be controlled if, in the process, the needs from which it springs are ignored."[106] Fundamentally, technology is but an extension of the human person and for Callahan the problems "posed by technology are, for that very reason, reducible to the problem of what man is to do with and about himself."[107]

The exposition thus far has indicated the elements that are basic to what Callahan calls the science of limits. It must proceed from "a re-creation of the cultural super-ego in its response to technology" and unfold in the formation of the virtuous citizen who will live realistically.[108] Callahan understands a science of limits to be

> a system of prohibitions, denials and interdictions which establishes the limits of technological aggressiveness, the limits of technological hope, and the limits of technological mandates (social and individual). The

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102 Callahan, *The Tyranny of Survival*, 75-76

103 "The satisfaction could be false either in the sense that technological societies exacerbate ordinary needs, and then offer more technology as a solution to the new problem thus created, or in the sense that false and harmful objects of satisfaction are offered." Callahan, *The Tyranny of Survival*, 76

104 Callahan, *The Tyranny of Survival*, 76

105 Callahan acknowledges the cumulative power of technology, i.e. different technologies feed on and strengthen each other.(p.80)

106 Callahan, *The Tyranny of Survival*, 78

107 Callahan, *The Tyranny of Survival*, 81.

108 Callahan, *The Tyranny of Survival*, 246. The reference to "cultural super-ego" is grounded in an earlier chapter of the book where Callahan uses Rieff's *Freud: The Mind of the Moralist* as a springboard for his critique of the tyranny of individualism.

> word "no" perfectly sums up what I mean by a limit, a boundary point beyond which one (we) should not go.[109]

Two corollaries flow from what Callahan calls the tyrannies of individualism and survival:

> Individualism does not know how to say No to the private self and its desire to outwit and circumvent the needs of the whole community; it can only say No to society, not to itself. The tyranny of survival is that it does not know how to say No to the needs of the community and the species; it can only say No to individual needs and desires.[110]

Callahan suggests three limits that should accompany technology. The first derives from what he calls the *biological reality principle*. The limits of human biological makeup restrict the human imagination as it looks for indefinite improvement. The *social reality principle* provides the second set of limits to technology. Any tampering with social orders and structures is judged to be *careless* when the proponents of technology assume that every problem, regardless of its nature, is amenable to a technological solution.[111] The third limit springs from the *psychological reality principle* which asserts that human beings are unlikely to give up their attempts to find happiness through technology. What is required is a sober understanding of its strengths and limits.[112]

This way of thinking leads Callahan to propose an ethic of technology which accepts the reality of technology in our society. The ethic Callahan envisages is a social one balancing the rights of individuals with those of the community. However, in "the absence of shared norms, there exist no grounds for questioning technological innovations, no standards for judging the consequences of technological change (even when we know the consequences), and no ways of restraining a technological imagination which, we can be sure, will continue to offer nirvana to unhappy, alienated individuals and societies".[113] What is required is a public morality which "relies on well-established general moral principles, binding on individuals and governments, setting limits to what individuals may ask for and do in their own behalf, and to what governments may ask for and do in behalf of the people."[114] In

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[109] Callahan, *The Tyranny of Survival*, 249.

[110] Callahan, *The Tyranny of Survival*, 250.

[111] "When survival and technology join hands, a technological imperative is introduced: the technology must be used...That is the ultimate social pathology which technologies introduce; there can be no turning back." Callahan, *The Tyranny of Survival*, 256-257.

[112] Callahan, *The Tyranny of Survival*, 257-258.

[113] Callahan, *The Tyranny of Survival*, 262

[114] Callahan, *The Tyranny of Survival*, 265

these words Callahan sketches the communitarian ethos that permeates all his written works.

The French philosopher Condorcet in 1795 spoke of the *unlimited progress* that was possible for medicine. Callahan observed that Condorcet's optimism has been clouded by two factors. The first is that not every medical advance is necessarily progress and, secondly, escalating costs of medical progress impose great strains on the finances of developed countries.[115] In fact the "very nature of medical progress is to pull to itself many more resources than should rationally be spent on it, often more than can be of genuine benefit to many individuals, and much, much more than can be socially justifiable for the common good."[116]

Medical progress feeds off at least three factors: the increasing number of the aging population, the technological developments that have occurred and the power of public demand. The cost burden has been fuelled by (1) the great profitability of the American health care system, (2) the prevailing individualism of the society which escalates needs and desires and (3) the drive for equality which seeks to extend benefits to all. In this context Callahan again returns to the role of human needs. He briefly considers bodily, psychological and functional needs and reiterates that a "denial of the limits of the possible in effecting cures is . . . a central part of the ideology of scientific medicine."[117] Another consequence of a dominant medical progress is that, with no boundaries on meeting individual needs, a wider gap is created by individual calls on the health care system. This results in what Callahan refers to as the *vertical gap* of care. Costs between the least expensive and most expensive patients have widened for care that is curative and life-saving. This vertical gap arises as a direct result of seeking to meet individual needs[118]:

> By virtue of redefining what is *normal* and having more success at the margin, the possibilities of pursuing individual need become unlimited. It is just such situations, of course, that have occasioned a hope in cost-benefit analysis. But precisely because there is no way to quantify, or

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115 D. Callahan, "Setting Limits in Health Care" in *Ethics in Medicine. Individual Integrity Versus Demands of Society*, edited by P. Allebeck and B. Jansson, (New York: Raven Press, 1990), 56

116 D. Callahan, *What Kind of Life? The Limits of Medical Progress*, (New York: Simon and Schuster, 1990), 21

117 Callahan, *What Kind of Life?*, 50

118 Callahan also notes the different forms of the vertical gap: (a) the gap between different patients with the same condition; (b) the gap between common, inexpensively treated conditions and those with rare, expensively treated conditions; (c) the gap between those with common diseases for which cures already exist and those that are both rare and as yet untreatable, but which might be solved after more research. Callahan, *What Kind of Life?*, 52

> morally judge, the comparative benefits of meeting quite different individual needs, the techniques must fail.[119]

In his most recent book Callahan returns to the question of progress and human needs by discussing *technological brinkmanship*. He defines it as

> the gambling effort to go as close to that line as possible before the cessation or abatement of treatment. Common sense seems to dictate such a course: aggressively work to prolong life until it becomes futile, or harmful, to continue doing so; then just as boldly, halt life-extending treatment.[120]

He locates the problem of technological brinkmanship in the act of human discernment. Basically it is the claim that we can manage our technology and its effects with the precision necessary to make brinkmanship succeed.[121] This way of thinking fails to reckon with two factors that make brinkmanship so difficult. "The two realities are the vanishing line between life and death, which makes it difficult to determine when to stop the use of technology, and the continuing profound public and medical ambivalence about what is wanted and valued in coping with illness and dying."[122]

Callahan continues to explore the consequences of medical progress in two closely related discussions. The first explores the notion of the *technological imperative*:

> If a technology is potentially available to combat disease, the compulsion to use it will be overwhelming, even if evidence of its efficacy is lacking. Technology makes action possible, and for most physicians, doing something is preferable to doing nothing.[123]

Complementing this is an equally significant issue.The real power of technology lies in its seeming capacity to turn what seems fixed and unavoidable into the malleable and contingent, open to radical change. Once that power is understood, the next step is not far behind. Reality itself, the nature of nature, can be transformed.[124]

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[119] Callahan, *What Kind of Life?*, 52-53.

[120] D. Callahan, *The Troubled Dream of Life. Living with Mortality*, (New York: Simon & Schuster, 1993), 41

[121] In this regard Callahan identifies two massive illusions. "One of them is the naive belief that the watchful self, aided by the right laws and medical practices, can master the body by means of carefully controlled medical technology...The other illusion complements the first: that we can know ourselves and our own wishes well enough to manage ourselves with the same precision with which we would control the technology, that we will understand ourselves well enough to know when to give up the struggle to stay alive." Callahan, *The Troubled Dream of Life*, 37

[122] Callahan, *The Troubled Dream of Life*, 42.

[123] D. Callahan, "Transforming Mortality: Technology and the Allocation of Resources", *Southern California Law Review* 65:1 (1991): 205.

[124] Callahan, "Transforming Mortality...," *Southern California Law Review*, 205.

Close alongside the technological imperative stands Callahan's understanding of the moral logic of medical progress:

> By *moral logic* I mean the way in which progress, in the initial sense of scientific possibility, becomes a moral imperative: what can be known, ought to be known, and what can be done, morally ought to be done. The *could* of medical possibility quickly transmutes into the *ought* of moral necessity.[125]

The eliding of technical and moral imperatives is a significant element in the contemporary medical ethos. If the conquest of disease is not pursued humans are morally at fault, for people will die who need not die. This logic expands in two directions. The first is the extension of personal moral aspirations for the individual's benefit. The second is the ever widening scope of its claim upon public funds for the dissemination of new technologies:

> The dynamic of progress, therefore, turns out to have two faces. It seeks to better our mortal condition, and when in the proces of doing so it adds new liabilities, it expects progress to take care of them as well.[126]

What results from this moral logic is a medical progress which constantly changes the accepted meaning of medical need, escalating and redefining it to bring it into line with the available technology. Human medical need becomes not something given in the nature of things, but a function of the capacity of the available technology to bring about a desired end. That is in part why new technologies, optional in their initial use, eventually become routine and mandatory in their later use. Once they are thought to meet need, which they have helped to define, their use cannot readily be denied.[127]

The moral logic of medical progress is further explored by Callahan when he discusses the link between medicine and nature. In its modern struggle to combat illness and death, medicine came to confuse its power to alter, control and eliminate disease with its power to banish mortality. At the same time, it has managed to blur the dividing line between human powers and the powers of nature.[128] In this area Callahan isolates an important insight. Until recent times it was possible to distinguish between physical causality (the impersonal, independent force of biological processes) and moral culpability (the responsibility of human beings for their actions, or omissions, in response to those processes):

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125 Callahan, "Transforming Mortality...," *Southern California Law Review*, 207

126 Callahan, "Transforming Mortality...," *Southern California Law Review*, 209.

127 Callahan, "Transforming Mortality...," *Southern California Law Review*, 209. Callahan takes the logic of medical progress to its ultimate conclusion. It has no inherent stopping point other than the elimination of death.(*ibid.,* 210)

128 Callahan, *The Troubled Dream of Life*, 59

> Where once we human beings as moral agents stood helpless in the face of nature, whose workings were outside the range of our responsibility, now everything is in some sense thought to be our responsibility. Causality and culpability have been collapsed together.[129]

The ethos of technological monism reduces all to the technical. What nature does becomes irrelevant. Technology, therefore, imposes a new determinism on human life. To deal with technology's power and influence in the contemporary world Callahan attempts to develop criteria of assessment. The context for these criteria is to be found in the intensification of care on the one hand and the opening up of a vertical gap in the delivery of care on the other. Two principles for assessing the use of technology have been proposed by Callahan. The first, or *principle of health symmetry*, requires that a

> technology should be judged by its likelihood of enhancing a good balance between the extension and saving of life and the quality of life. Its aim is to promote medical coherence, by which I mean outcomes that foster the rounded well-being of persons, not simply one-dimensional improvements that benefit some aspect of individual well-being at the expense of others.[130]

The second criterion combines the two *principles of technology assessment*:

> A technology should be judged a failure, or a distinct social threat, under two circumstances: when it medically fails to achieve, or achieve well, its stated purpose; and when its success would tend to create significant distortions in the healthcare system, especially that of threatening societally necessary limits on the frontiers of aging and individual need.[131]

Callahan's stated aim in offering these principles of technology assessment is to focus attention on the need to identify and debate the moral, social and cultural ends technology should serve. The criteria are offered as standards for assessing technologies in the light of these ends.[132]

4.2.1.3 The Individual and the Common Good

Callahan's understanding of the individual's place in community is first encountered in his analysis of individualism and its tyranny.[133] His study builds on two books by Philip Rieff: *Freud: The Mind of the Moralist* (1961) and *The Triumph of the Therapeutic: Uses of Faith after Freud* (1966). Rieff maintained that Freudian

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[129] Callahan, *The Troubled Dream of Life*, 67

[130] Callahan, *What Kind of Life?*, 164-165

[131] Callahan, *What Kind of Life?*, 167.

[132] Cf. P.Boyle and D. Callahan, "Technology Assessment: The Missing Human Dimension", *The Hastings Center Report* 22:3 (1992): 38-39.

[133] This section is dependent on Callahan, *The Tyranny of Survival*, 111-135

psychoanalysis makes possible a morality dedicated to the promotion of the private self. The private life is unalterably opposed to communal life. When they conflict then the bargaining begins. According to Rieff a demand for honesty permeates the therapeutic work of Freud. For Freud the successful patient is one whose honesty ultimately liberates him or her not from the self but from others. The ideal of community, with its built-in sacrifices, suppressions and suffocating moral ideals, must be overcome.[134] As Callahan notes:

> *Psychological man*, the virtuoso of this inner life, is becoming the model individual of our day. If the *derangement of communal life* cannot be overcome by social reform or manipulation, then the individual must look to himself for salvation.[135]

Callahan builds on the therapeutic approach to life that Rieff has situated in the work of Freud. This therapeutic approach to life substitutes "analysis for ideals, theory for belief, detachment for commitment, and coolness for ardor"[136] The cultural milieu of the contemporary psychological human entails a system of remissions and releases, controls and restraints. In place of a culture dependent on faith or any sharing of communal purposes modern society attempts "to fashion a culture where the shared interest in self-interest provides the only tie which binds people together."[137] This new culture differs considerably from the old. The latter viewed human well-being as constituted by membership of the community. Membership required a considerable degree of asceticism, conformity to the common theology and public philosophy, a sublimation of the individual. Psychological man, on the other hand, is

> one who uses the analytic attitude in his own service; it enables him to withstand the culture, to remove himself inwardly from it, to defend himself against its incursions. By its anticreedal stance, the analytic attitude enables us to live without meaning and purpose.[138]

This new culture emphasising release is made possible economically by the spread of affluence and therapeutically by psychoanalysis. Well-being in this new world consists in the capacity to resist, not join the community.

Callahan considers the two tyrannies of individualism and survival to be

> proof against any kind of social ethic, for both dissolve that necessary dialectic between individual and community which is the prime

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[134] Callahan, *The Tyranny of Survival*, 121.

[135] Callahan, *The Tyranny of Survival*, 121.

[136] Callahan, *The Tyranny of Survival*, 122. This is a succinct expression of the agenda of modernity. For a fuller presentation of its elements see S. Toulmin, *Cosmopolis: The Hidden Agenda of Modernity*, (New York: Free Press, 1990)

[137] Callahan, *The Tyranny of Survival*, 125.

[138] Callahan, *The Tyranny of Survival*, 126

> requirement of such an ethic. A failure in the first place to posit the validity of both individual and community will make it impossible in the end to combat the virulence of individualism and survivalism, a virulence which paradoxically draws them closer together with every advance in technology and affluence.[139]

The above exposition has indicated Callahan's use of Rieff and, in doing so, has isolated a number of insights that have influenced Callahan's communitarian theory. These emphases have underpinned his writings during the last two decades.

Callahan's communitarian credentials are to be seen in his analysis of the autonomy proper to the individual. He acknowledged the many benefits that have resulted from giving moral priority to autonomy, but warns that if autonomy becomes the moral goal of a society, or of medical care, it will undermine life in common.[140] To substantiate this point Callahan outlines seven social uses of the notion *autonomy*: (1) As moral agents, we are essentially independent of each other and isolated. We are not social animals, but morally self-enclosed, self-encompassing animals. (2) There can be no moral truth or wisdom about individual moral goods and goals and few if any about communal ends. Morality is inherently subjective and relativistic. (3) The ideal relationship among human beings is the voluntary, contractual relationship of consenting adults. The community has no standing to say what is good or bad in such relationships. (4) In any weighing of the relative interests of individual and community, the burden of proof is always on the community to prove its case for restricting the liberty of individuals. (5) The only moral obligations an individual has towards others are those voluntarily undertaken. There can be no such thing as an involuntary moral obligation. (6) The only moral obligations that people have toward an individual are those that the latter allows them to have. All that is owed by others is respect for an individual's autonomy. (7) Respect for the autonomy of others is sufficient ground for overriding one's own conscience.[141] These seven perspectives encompass a morality of autonomy that Callahan repeatedly confronts in all his writings. Where autonomy is given priority it is judged as so important as to trump all other values. Two consequences flow from this. The first is the relationship between autonomy and justice. Callahan acknowledges that many theories of justice claim to give justice priority over autonomy. Nevertheless he points out that

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[139] Callahan, *The Tyranny of Survival*, 135

[140] Among the benefits he singles out: recognition of the rights of the individual and his or her personal dignity; the erection of a powerful bulwark against moral and political despotism; a becoming humility about the sources or certainty of moral claims and demands; and a foundation for the protection of unpopular people and causes against majoritarian domination. D. Callahan, "Autonomy: A Moral Good, Not a Moral Obsession", *The Hastings Center Report* 14 (1984): 40

[141] Callahan, "Autonomy...," *The Hastings Center Report*, 41

> the most popular and influential contemporary theories of justice (at least in the United States) see the source of a theory of justice in individual needs and desires, and the outcome of a reign of justice as the enthronement of individual autonomy. Justice becomes little more than a way station on the road to self-determination.[142]

This particular convergence of justice and autonomy has a second impact namely the exclusion of community:

> There can be no valid community unless its citizens have some sense of a common good, one that transcends the sharing of procedural protections. Despite what supporters say, an emphasis upon autonomy does seem to gut a mutual seeking of a common good. Indeed, there is no such thing as a *common good* under a reign of autonomy; there is only the aggregate of individual goods.[143]

In view of this dominance of autonomy, Callahan wishes to maintain autonomy as *a* value, not *the* value in contemporary life.[144] In more recent times Callahan has isolated another aspect of moral autonomy and highlighted a significant outcome. Choice, the exercise of individual autonomy, has become more important than the issue about which the choice is made. Callahan illustrates this in regard to the current push for a choice about death. Contemporary apologists for voluntary euthanasia choose

> 'choice' about death, rather than death itself, as the new, supposedly liberating focus . . . The more public becomes the espousal of choice, the more private the content and substance of that choice.[145]

The image of the ideal self that has become entrenched in this ethos is based on two convictions. The first is that nature can be brought under human control and the second is that humans have an autonomous right to find their own individual way, to control their living and dying. In reaction to this Callahan invokes an "image of the self that is more flexible, less manipulative, more interdependent with others, more open to risk, a self appropriate to a peaceful death."[146] Callahan rejects "the mistaken belief that a *necessary* condition of our self-worth is our control of our lives."[147] Even though many people today would like to deny a fixed self embedded in a fixed body, both possessing an inherent nature, the reality of illness and death will not permit this

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142 Callahan, "Autonomy...," *The Hastings Center Report*, 41

143 Callahan, "Autonomy...," *The Hastings Center Report*, 42

144 Callahan notes that the "interesting and important work of morality is not the achievement of autonomy but the uses to which it is put and the moral ends it is fashioned to serve." Callahan, "Autonomy...," *The Hastings Center Report*, 42

145 Callahan, *The Troubled Dream of Life*, 35. He further observes that "(t)here is, in fact, a kind of inverse correlation between the language of meaning and moral substance - the content of choice - and an emphasis on the right to make a choice."(*ibid.*, p.36)

146 Callahan, *The Troubled Dream of Life*, 126

147 Callahan, *The Troubled Dream of Life*, 153.

denial. He has concluded that it is an enormous error "to act as if the possession of choice could obviate the need for the kind of individual character necessary either to make good choices when we have them to make, or to live well and without despair in the absence of choice."[148]

Throughout this discussion of individualism, autonomy and choice Callahan has always emphasised the counter-values of community and the common good. Repeatedly in discussions of illness, health care, dying and death Callahan has emphasised the nature of human lives in common. His analysis of the problem of chronic illness well illustrates this preoccupation. The provision of care for the chronically ill acknowledges, he says, "the links that join the sick and the well, the young and the old in a community of common humanness and vulnerability."[149] As public policies are developed for the chronically ill "rights-based conceptions of social justice and individualistic conceptions of interests and autonomy should be tempered by a communitarian perspective."[150]

4.2.2 Human Experiences Throughout the Life Span

4.2.2.1 Health and Illness

Daniel Callahan has referred to the *mirage of health*, the desire for a complete and lasting freedom from disease.[151] He discusses it in terms of the human drive for indefinite progress, where all individual needs for cure and the avoidance of death are fulfilled. The imbalance created by aspirations of this kind manifest themselves in the areas of health, health care and medicine. A true balance must come, he says, from "a coherent perspective on the general welfare of the society as a whole"[152]

The clear indicator of an expansionist view of health is to be found in the World Health Organisation's definition: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[153] According to Callahan a number of consequences flow from an expanded understanding of human

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[148] Callahan, *The Troubled Dream of Life*, 155.

[149] B. Jennings, D. Callahan and A. L. Caplan, "Ethical Challenges of Chronic Illness", *The Hastings Center Report* 18:1 (1988): S15

[150] Jennings, Callahan and Caplan. "Ethical Challenges...," *The Hastings Center Report*, S15

[151] The expression is taken from René Dubos. See D. Callahan, "Modernizing Mortality: Medical Progress and the Good Society", *The Hastings Center Report* 20:1 (1990): 29.

[152] Callahan, "Modernizing Mortality...," *The Hastings Center Report*, 29.

[153] See Callahan, "Biomedical Progress...," in *Ethics and Health Policy*, 160-161 and Callahan, *What Kind of Life?*, 34-40

health. First, the notion of well-being that incorporates the aspect of social well-being, has transformed the problems of human happiness and well-being into a medical problem. Second, health is only part of life and the attainment of health only a part of the achievement of satisfaction with one's life. No matter how important medicine is, its role is limited. Third, for an individual to be healthy and well does not necessarily require that the person be whole in every way.[154]

Two understandings of health must, therefore, be distinguished: health as a *norm* and health as an *ideal*. As a norm it is possible to speak in terms of deviation from statistical standards, especially those applying to organic and behavioral functioning. Health as an ideal, on the other hand, is not just a set of averages but is assessed in terms of it being a *good*. Understood in this way it is impossible to distinguish conceptions of human good (what benefits the self and its goals) from statistical norms of the body. This aspect is highlighted by the WHO definition which sees a close link between the good of the body and the good of the self. What the definition fails to accept is that for a person to be happy it is not necessary that she or he be healthy; being healthy does not require a person to be happy.[155]

Pursuing this line of thought further has lead Callahan to consider needs and goals in the areas of health and health care:

> We call something a need because, unless it is met, we cannot achieve our other goals; yet that means we can say little about the significance of the needs unless we can define these goals. How much and what kind of health we want depends in part on what we want to do with our life.[156]

In the realm of health Callahan discerns bodily, psychological and functional needs. It is the goal of medicine to meet these health needs.

Social implications play an important role in Callahan's analysis of health. Both health and illness have personal and public dimensions.[157] It is not possible, he has argued, to have an adequate understanding of health, and hence fashion a viable health care system, unless attention is given to the social dimension of health.

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[154] Callahan, *What Kind of Life?*, 36-37.

[155] David Armstrong in *Political Anatomy of the Body. Medical Knowledge in Britain in the Twentieth Century*, (Cambridge: Cambridge University Press, 1983), 85-117 argues, in line with Foucault, that the Anglo-Saxon twentieth century world has shifted the gaze of medicine from the body to the spaces between bodies. This is mirrored in definitions of health.

[156] Callahan, *What Kind of Life?*, 40

[157] See Callahan, *What Kind of Life?*, 102-134 and Callahan, "Modernizing Mortality...," *The Hastings Center Report*, 29-30.

Individuals pursue good health as a necessary condition for living with oneself and with others. It is a means in the negative sense (good health is sought so as to avoid pain and suffering) as well as a means in a positive sense (good health is aspired to in order that other life goals be achieved). Since health is a means and not an end, individuals often get by with less good or ideal health than they would wish. On occasion they accept less than they could be reasonably said to need[158]:

> Society and culture provide us, among other things, with the values with which we judge the state of our health in comparison with others, our expectations about our health and what it is reasonable to hope (or not hope) for, the meaning and significance we bring to our illness, decline and death, and our sense of the potentialities for improved health.[159]

Out of this awareness comes an understanding of the way people learn to adapt to the level of health available in their society. They may hope for more but will, if necessary, settle for less. This raises the question as to the proper place health should play in a social way of life. For Callahan the primary goal, "the highest priority, of the healthcare system as a curative effort should . . . be that of fostering the common good and collective health of society, not the paticularized good of individuals."[160] In giving priority to the health of the social unit Callahan expresses his conviction that health is a common benefit, something needed for people to live together. In elaborating the link between individual health and the common health of society he presumes five goals for society.[161] Callahan's thesis requires broad agreement on the goals of society and on the level of vigour its major institutions must have for these ends to be achieved. These directly influence health and health care:

> *Not one* of these ends requires perfect or optimal health; they are compatible with a wide range of individual illness and disability. *Not one* of them requires an unlimited pursuit of medical progress, much less the kind of unrelenting war against aging, decline, and death that our system seems eager to wage. *Not one* of them requires a constantly growing proportion of the gross national product to be devoted to healthcare. *Not one* of them requires the achievement of the WHO definition of health, the meeting of all individual curative needs as defined by the progress of medicine, or attaining the highest-quality healthcare.[162]

It is not necessary here to explore what level of health is appropriate for a society to function properly. Callahan has sought to clarify the basic, yet relative value of

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[158] Callahan, *What Kind of Life?*, 107-108

[159] Callahan, *What Kind of Life?*, 109.

[160] Callahan, *What Kind of Life?*, 110.

[161] He nominates (1) maintenance of political and legal systems; (2) solid economic order; (3) national defence; (4) transmission of knowledge and culture; (5) maintenance of the basic institutions that bond society, e.g. the family, churches, voluntary organisations.

[162] Callahan, *What Kind of Life?*, 112-113.

health in a social context. At the same time he has attempted to circumscribe the obligation of society vis-a-vis the health of an individual. Social and interpersonal dimensions of human living are the appropriate focus of health care (at least in its curative role). When health care attends only to the private and unique dimensions of individual life - as proposed by the notion of *complete well-being* in the WHO definition - then health care goes astray.

The concrete realities of health care in the U.S.A. make the preceding discussion more than ever urgent. As an increasingly larger amount of money is being expended on the elderly, where the dying elderly consume a disproportionate percentage of the health care dollar and where medical advances initially not intended for the elderly (e.g. dialysis) are being used on them, it is imperative that the social and individual dimensions of health and health care be clarified. This has been one of Callahan's primary tasks.[163]

Directly related to the social and individual dimensions of health and health care, in Callahan's mind, is the question about the goals of medicine. This has been a constant and recurring theme in all his writings. He sees modern medicine as forever on the edge of two great and endless frontiers. One is the frontier of aging (with its possibilities of extending the life of elderly persons) and the second is the frontier of the individual cure, for there is no end to the possibilities of seeking to cure illness and save lives.[164] Discussion of the goals of medicine is to be found most often in Callahan's analysis of the goals of aging. Cure of disease and relief of suffering, each of which is a threat to human wholeness, have long been accepted as appropriate goals of medicine. "Disease destroys the wholeness and integrity of the body, and pain and suffering can destroy the wholeness of the person."[165] In this context an appropriate and prudent goal for medicine must be to provide a reasonably healthy life in the context of a human life that is, of its nature, finite and bounded.[166] Callahan goes further and suggests three aspirations he has for curative health care. The first is that medicine should meet bodily needs - a full life span and avoidance of premature death. Secondly, medicine should meet cognitive and emotional needs, assisting the

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163 D. Callahan, "Aging and the Ends of Medicine" in *Biomedical Ethics: An Anglo-American Dialogue. Annals of the New York Academy of Sciences*, edited by D. Callahan and G. R. Dunstan, Vol. 530, (New York: The New York Academy of Sciences, 1988), 126.

164 D. Callahan, "Rationing Health Care: Will It Be Necessary? Can It Be Done Without Age or Disability Discrimination?", *Issues in Law and Medicine* 5:3 (1989): 356

165 Callahan, *Setting Limits*, 77

166 Callahan, "Setting Limits...," in *Ethics in Medicine*, 58

individual to attain a psychologically stable mental and emotional state. Thirdly, medicine ought meet functional needs.[167]

In the specific context of aging Callahan argues that medicine "should give up its relentless drive to extend the life of the aged, turning its attention instead to the relief of their suffering and an improvement in their physical and mental quality of life."[168] A complementary goal for medicine in aged care is to help the elderly maintain a physical and psychological life sufficient to enhance the realisation of their aspirations. This does not demand more life, but a life free of whatever pain and suffering that might impede these ends.[169]

Callahan also ponders the goals of medicine in his study of chronic illness. The increasing prevalence of chronic illness, especially among the elderly, is challenging medicine in new ways. Not only does it force a re-appraisal of the ends of medicine, it also questions the traditional boundaries of care and challenges the community in the area of social justice. In a society that values curative medicine chronic illness forces a radical re-think. Care of the chronically ill must proceed with an awareness that chronic illness is a component of the person's overall state of being:

> The overall goal of chronic care is to mitigate the limitations that chronic illness inevitably brings with it in a person's life, and to control the damage that the illness might otherwise do. More specific, clinically defined goals such as rehabilitation, pain relief, and the control of symptoms through drug therapy, diet and exercise are consonant with this end.[170]

Callahan's understanding of the goals of medicine and the need for limits in health care is directly linked to the issues of medical futility and medical necessity. Both matters have arisen as a result of the capacity to sustain life even in its most fragile and terminal phases. The issue of futility hinges on the question whether it is possible to say, on scientific grounds alone, that some kinds of medical treatment will be useless for certain types of patients. Related to this is whether doctors have the unilateral right to decide both what is futile and whether they should inform patients or their families.[171] Callahan urges a respect for the integrity of both doctor and patient. Development of general social standards that will assist people to make value

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[167] Callahan, *What Kind of Life?*, 156.

[168] D. Callahan, "Is a Longer Life a Better Life? Our Society Has Lost Sight of Quality." *Washington Post Health* 3:36 (1987): 6. See also D. Callahan, "Aging...," in *Biomedical Ethics: An Anglo-American Dialogue*, 126.

[169] Callahan, "Is a Longer Life...," *Washington Post Health*, 7.

[170] Jennings, Callahan and Caplan. "Ethical Challenges...," *The Hastings Center Report*, S10.

[171] D. Callahan, "Medical Futility, Medical Necessity. The-Problem-Without-A-Name", *The Hastings Center Report* 21:4 (1991): 30-35.

judgments on the basis of medical facts is urgently required. Medical necessity, on the other hand, has had a longer history in bioethical literature. The term in practice has come to mean "whatever medicine can in fact do to meet whatever different people fancy as necessary; the concept is thus elastic and technology-driven."[172] In light of the complexities embedded in both notions Callahan has concluded that the standard of medical necessity alone is inadequate for providing an adequate level of health care. Such a standard requires wider consideration:

> The final result. . .must be multilayered. At least five elements have emerged that must be part of that result: (1) medical need defined in some general way; (2) the efficacy of available treatments in meeting that need; (3) the comparative costs and benefits of those treatments; (4) the necessity of setting health care priorities; and (5) a political process capable of making the combined medical and moral judgments that will unavoidably be encountered along the way. To these elements I would add still another: (6) the stimulation of public and professional debate on the substantive content of the moral judgments.[173]

The struggle to define medical futility and necessity has proceeded with a naive expectation that good medical information would resolve the issue. Instead, a wider analysis of moral, economic and political issues has been necessary.

Lack of clarity about futility and necessity has caused both the individual and society to live on what Callahan calls the *ragged edge* of medical treatment and progress.[174] No matter how far the frontiers of medical progress are pushed forward there is always a ragged edge - with poor outcomes, with cases as bad as those that medical science has succeeded in curing, with the inexorable decline of the body. The ragged edge of medical progress is as much part of that progress as is its success. As with the earlier question of progress the challenge here lies in knowing when and how to stop.

This realisation leads to a central value shift that Callahan proposes for contemporary health care. Scientific medicine has given great importance to curing disease. Callahan's critique has been levelled at two elements in the campaign to cure. First, the power and momentum of technology creates an imperative and a moral logic for cure. Second, priority has been given to individual needs in the area of health care. Callahan proposes an alternative approach: society must give priority to *care* over *cure*:

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172 Callahan, "Medical Futility...," *The Hastings Center Report*, 33

173 Callahan, "Medical Futility...," *The Hastings Center Report*, 34

174 Callahan, *What Kind of Life?*, 63-65

> While the need for caring can be extensive, costly, and burdensome, it does not have about it the inherently open-ended features that mark the need for cure. If all the needs of the body for cure cannot be met, as they can never be, the emotional and social needs of the person whose body is sick can usually be met to some minimally adequate extent. That effort does not require endless technological innovation, or constant breakthroughs on the frontiers of research. It requires that adequate provision be made to relieve pain, to provide institutional and home care when family resources fail, and to provide counseling and support in the face of suffering. What caring requires, for the most part, is concern and sympathy, time and personal attention.[175]

Caring is a response to the vulnerability created by illness in the life of another person. Callahan defines it as "a positive emotional and supportive response to the condition and situation of another person, a response whose purpose is to affirm our commitment to their well-being, our willingness to identify with them in their pain and suffering, and our desire to do what we can to relieve their situation."[176] The caring response embraces two aspects. It entails, first, the attitudes and personal traits the carer brings in the act of caring. The second element includes the way responses are socially structured so that comfort and security are provided for the ill person. Callahan argues that caring should always take priority over curing. Where the individual need for cure is infinite in its possibilities, the need for caring is much more finite. There is always something that can be done for another. The assurance of care conveys to the sick person a neighbourly commitment whether a cure is possible or not. Callahan focuses on the needs which the experience of illness and disability bring to the fore. Fear of death, loss of self-control, separation from others and suffering are but some of the elements that human caring addresses. Caring is directly person-centered in a way that technological medicine frequently is not. It challenges on two fronts. First, the ability to care requires a capacity to acknowledge one's own mortality and our common vulnerability. To understand the privacy and hiddenness of much pain and suffering in others requires imagination in the carer.[177] Second, caring demands a particular type of social response. It necessitates particular institutions, accommodating social structures and a society prepared to make room for those it cannot cure or return to productive life.

Throughout his discussion of the curing-caring dichtomy Callahan is at pains to point out that he speaks the language of *priorities*.[178] He views the shift of focus in

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175 Callahan, *What Kind of Life?*, 66-67.

176 Callahan, *What Kind of Life?*, 144.

177 Callahan, *What Kind of Life?*, 148.

178 "The point of a priority is to give a general bent and coloring to the system. It is not a prescription for inflexibility, and it admits of reasonable exceptions." Callahan, *What Kind of Life?*, 150.

contemporary health care as requiring a sort of *implosion*. He urges Americans to direct their quest for health care inward rather than outward. In saying this he indicates his commitment to altering the profound philosophical and spiritual underpinnings of his society. He does not deny the importance of curative medicine but, instead, argues that it may well be necessary for Americans to accept that they

> *already* have a sufficient level of societal health (with some noted exceptions). The second requirement is that we acknowledge the primacy and necessity of providing care for all, and only then pursue our aspiration to move beyond care to cure where sensible and possible.[179]

Callahan is convinced that a health care system that bases itself on the need individuals have to be cared for will return health care to continuity with the richest and deepest traditions of medicine.[180] This is at odds with the prevailing ethos which emphasises the individual's *right* to health care. For Callahan the right "may be defined as a legitimate claim of the individual on society to have his or her health needs met."[181] But, how are the nature and extent of this obligation to individuals to be determined? What does it mean to pursue a right to health care where medical progress has altered the notion of individual need? Callahan contends that this question is impossible to answer. As noted in his earlier discussion of individual needs the claim of a right to health care becomes hopelessly vague and open-ended. There are no intrinsic limits. Lacking is any clear notion about the kind and scope of health care that is actually owed to another in society. "We can give no clear meaning to terms such as *adequate care* or *minimal needs*, and thus cannot establish policy in any sound way."[182] Callahan illustrates this by referring to the way congressional funding has been extended to dialysis in the U.S.A. It has expanded beyond all expectations. Callahan argues that the obligation to provide health care, as a correlative of the right to health care, must be limited. It must also be grounded on social and not on individual moral foundations. Furthermore, intrinsic limits to the right to health care must be accepted:

> These limits stem from the fact that the human body is a finite material organism, subject to decay and eventual dissolution. Illness is one manifestation of human finiteness. The demand for an absolute *right to health care* is, in the end, a demand to be free of bodily finiteness.[183]

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179 Callahan, *What Kind of Life?*, 150.

180 Callahan, "Modernizing Mortality...," *The Hastings Center Report*, 32

181 Callahan, *What Kind of Life?*, 57

182 Callahan, *What Kind of Life?*, 60

183 Callahan, "Biomedical Progress...," in *Ethics and Health Policy*, 165

Reference has already been made to the impact that chronic illness has had on our understanding of medicine. In an interesting discussion of rehabilitation medicine Callahan points to the way this form of health care is promoting new understandings of health care.[184] Traditional models of medical paternalism and the prevailing contract theories of health care are displaced by an *educational model* incorporating paternalistic, cooperative and liberating dimensions. Rehabilitative health care confronts limits in a number of areas. The extent of a family's obligation to care, a re-appraisal of medical intervention in catastrophic accident situtations and issues of resource allocation for those impaired for life, necessitate a wider social perspective in the understanding of health care. What results is a larger context for the rights that are claimed.

The present state of health care in the United States has already been sketched in chapter 3. According to Callahan a vision of long-term goals is lacking in the American health care system. For this reason cost-benefit analysis, technology assessment and applied justice theories have all failed.[185] He accepts that the goals of quality, equity and efficiency have been fundamental for the development of American health care. The overwhelming conviction is that these goals can be achieved through (1) greater biomedical knowledge, (2) advances in technological medicine resulting in reduction of costs and (3) the compatibility of medical progress and medical efficiency.[186] Callahan judges these beliefs to be false. The pressing need in the system at present is to provide an adequate minimum level of health care for all U.S. citizens and to find some effective way of cutting health care costs and its proportion of the overall budget.[187] The ongoing implementation of Medicare and Medicaid well illustrates the imbalanced, even *deranged* aspect of U.S. health care.[188]

In a number of places Callahan analyses the Oregon experiment.[189] In spite of quite wide-ranging criticisms of the experiment, the details of which need not delay us here, he supports the initiative. In all of this his primary concern is that the U.S.A.

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[184] A. L. Caplan, D. Callahan and J. Haas, "Ethical and Policy Issues in Rehabilitation Medicine", *The Hastings Center Report* 17:4 (1987): S1-S20.

[185] D. Callahan, "Organizing a Health Care Vision" in *Emerging Issues in Biomedical Policy. An Annual Review*, edited by R. H. Blank and A. L. Bonnicksen, Vol. 1, (New York: Columbia University Press, 1992), 146-148.

[186] Callahan, *What Kind of Life?*, 69-70. See also: D. Callahan, "The Oregon Initiative: Ethics and Priority Setting", *Health Matrix* 1:2 (1991): 157-158.

[187] D. Callahan, "Meeting Needs and Rationing Care", *Law, Medicine and Health Care* 16:3-4 (1988): 261.

[188] Callahan, *What Kind of Life?*, 70

[189] Callahan, "The Oregon Initiative...," *Health Matrix*, 157-70

introduce a universal health care system.[190] For Callahan a basic health care package necessitates development in two phases.[191] First, there must be a national discussion of the way health care relates to the other needs of society. Any system that evolves from such dialogue must be culturally relative, resource relative and sensitive to variations in individual needs. Second, the middle ground between the individual and the community must be adopted. In the light of this Callahan proposes five areas of health care in order of importance: (1) care is to be given priority over cure; (2) public health; (3) primary and emergency care; (4) advanced technological medicine, such as surgery, chemotherapy; (5) advanced technologies, for example organ transplantation and kidney dialysis.[192] Within this package it is reasonable, he argues, to give priority to the young over the old, the poor over the rich (particularly in government programs), family members over single people, and barring exceptions, life-saving care over other forms of health care.

Two sets of goals for the health care system provide the basis for Callahan's proposed health care package. The primary goal should be to provide those general measures of public health and basic medical care most likely to benefit the common health of the population as a whole, and to ensure that every person in the society receives care, comfort and support in the face of illness, aging, decline, and death. The secondary goal of the system, within the limits of a reasonable level of health care expenditure relative to other social needs, should be to pursue a basic understanding of the causes of illness and death. An attempt should be made to cure illnesses that bring premature death and thwart common human aspirations. [193]

4.2.2.2 Aging

In the West, particularly in first world countries, cost of health care is one indicator of an aging population. The growing number and proportion of elderly people in the population combined with the wide use of high-technology medicine has resulted in a massive escalation of costs.[194] The Medicare budget illustrates this phenomenon.[195]

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190 "Despite its obvious shortcomings, Medicare's universalistic incorporation of all the elderly represents a unique communal expression of social solidarity." R Bayer and D. Callahan, "Medicare Reform: Social and Ethical Perspectives", *Journal of Health Politics, Policy and Law* 10:3 (1985): 546

191 D. Callahan, "What is a Reasonable Demand on Health Care Resources? Designing a Basic Package of Benefits", *The Journal of Contemporary Health Law and Policy* 8 (1992): 6

192 Callahan, "What is a Reasonable...," *The Journal of Contemporary Health Law and Policy*, 9

193 Callahan, *What Kind of Life?*, 187-188

194 Chronic illness, the disproportionate number of elderly in the pool of ill and impaired people, the increasing necessity of moral choices in the care of the dying as a class are among the issues relevant here. See: D. Callahan, "Adequate Health Care and an Aging Society: Are They Morally

Despite two decades of effort cost control has failed. Callahan judges there is no possibility for future success in this area. Writing in 1989 he accepted projections that the number of elderly people in the U.S.A. would double over the following thirty years, with an even greater increase for those eighty-five and over.

Medicaid has expanded dramatically from its earlier emphasis on the poor. This has had two consequences. First, elderly people have had to *spend down* their life savings in order to qualify for long-term care and home care. Second, the Medicaid Bill contained a rider covering the long-term care of the elderly. This has skewed distribution of funds in favour of the elderly who now dominate the program.[196] Although only fifteen percent of all recipients the elderly now account for nearly forty percent of total expenditure.[197]

Reference has also been made to an increasing use of high-tech medicine and its extension to the elderly. Dialysis is the example to which Callahan most often refers. A solution to this growing crisis, according to Callahan, is to be found in curbing our insatiable appetite for a longer life at any expense. The alternative is

> the more bold, but now imperative, task of asking what is an acceptable and reasonable goal for health care support in old age. We need a more coherent and fair system. For this system to work, it must set limits to the care provided to the elderly, particularly life-extending technological care.[198]

Before taking up Callahan's solution in more detail it is necessary to mention two further matters related to the aging population. The first is the greater independence among the elderly. Many older persons seek to be as independent as possible for as long as possible. This independence does not indicate a weakening of family ties. However, the reality of increasing numbers of divorced families, the prevalence of small families and families with both spouses working are social changes that have altered family networks particularly in relation to the aged. In spite of this "children

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Compatible?", *Daedalus* 115:1 (1986): 247-248. Callahan also speaks of old age as a social avalanche in Callahan, *Setting Limits*, 20-22

[195] Callahan quotes 1987 cost projections for the Medicare program. An optimistic view sees a $27.3 billion deficit by 2000, and a $117 billion one by 2020. See: D. Callahan, "Health Care for the Elderly: Setting Limits", *St.Louis University Law Journal* 33 (1989): 558-559

[196] The reason most often quoted is that the elderly dying consume a disproportionate share of health care costs. See Callahan, "Aging...," in *Biomedical Ethics: An Anglo-American Dialogue*, 126.

[197] Note that children below the poverty line who are seventy percent of total recipients receive only about twenty-five percent of its benefits. This is an example of the "blocking" function of entitlement programs for the elderly. See Callahan, D. "Health Care for the Elderly: Setting Limits." *St.Louis University Law Journal* 33 (1989): 557-68, at pp.560-561

[198] Callahan, "Health Care...," *St.Louis University Law Journal*, 559

and families remain the principal source of emotional support and companionship for the elderly."[199] Dependence which increases with longevity and frailty is a second important factor. With frail old age the old person increasingly becomes dependent on others for the basic functions and needs of life. Dependency is thus a significant issue in this phase of the human life-cycle.

In coining the term *ageism* in 1968, Dr. Robert Butler has attempted to redress imbalances in the place of the aged in U.S. society. Ageism is a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism acomplish this with skin color and gender.[200] As Callahan observes:

> [o]ut of ageism came the *myths* of an inflexible progression of aging, indifferent to individual variations, of unproductivity, of disengagement, inflexibility, of senility, and of serenity. How were ageism and the myths it nourished, on the one hand, and the actual deprivation and poverty of the aged, on the other, to be combated? By a vigorous program of social reform, by medical research, by public education, and by an organized and politically active cadre of the elderly themselves.[201]

Callahan strongly criticises two strands of the political campaign against ageism in the U.S.A. These operate as the aging advocacy and pro-life movements. He believes they will not achieve necessary and significant changes in the lot of elderly Americans. According to Callahan the *advocates* see aging and society as both totally malleable entities. They accept, he says, only those temporary restraints which present scientific ignorance imposes. Implicit in this outlook is a refusal to recognise aging and death as inevitable parts of human life. Furthermore, despite claiming to accept the interdependence of generations, the movement possesses a very impoverished social perspective. The roots of this are deep in twentieth century liberalism, civil rights and reform movements. The movement can only ask for more for the elderly as individuals "because *more* is the modernizing, individualistic, diverting way to deal with the unsettling finitude of life in the absence of real meaning and significance for aging and death."[202] The pro-life movement may be criticised for its vitalism (where keeping alive at any cost is primary) and the same individualistic view of the aged that the political advocates have shown.

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199 D. Callahan, "What Do Children Owe Elderly Parents?", *The Hastings Center Report* 15:2 (1985): 33

200 Cf. Callahan, *Setting Limits*, 202

201 Callahan, *Setting Limits*, 202

202 Callahan, *Setting Limits*, 218

In light of this, what vision of aging does Callahan propose? He suggests five steps on the way to developing a more satisfactory vision of aging in American society. First, technology should be prevented from setting the agenda of the *possible*

> as if what is technologically feasible were humanly good. Our goals for medicine and aging would set those limits, based not on what technology could do, but on what we think it *ought* to do in light of wise human ends.[203]

Second, a distinction must be made between *tragedy, outrage* and *sadness*:

> It is a tragedy when life ends prematurely even though it is possible to save that life, and when old age is full of burdens even though resources are available to relieve them. It is an outrage when, through selfishness, discrimination, or culpable indifference, the elderly are denied what they need and deserve. But it is only a sadness, an ineradicable part of life itself, when after a long and full life a person ages and dies in a society that has cherished and supported that person through the various stages of life. It is wise to want to banish the tragedy and outrage, but not the sadness.[204]

Third, ways should be discerned to enable a common moral dialogue about the ends of medicine and aging. Fourth, there is a need to talk with greater depth about death and how it might be understood and faced. Fifth, the generations should be encouraged to talk together to understand their mutual responsibilities. This process in its varied elements will be explored in more detail in the following pages. Before this, however, it is necessary to consider the goals of aging.

Callahan has argued that a renewed understanding of the goals of medicine must be complemented by a re-appraisal of the ends and meaning of aging. First, it is necessary to appreciate that it is possible to live out a meaningful old age even though time is limited. There is no need to turn to medicine for more life so as to make the aging process bearable. Second, contemporary culture must ensure a supportive social context for aging and death. A culture of this sort cherishes and respects the elderly. At the same time there is a recognition that the primary orientation of elderly people should be to the young and the generations yet to come, not to the welfare of their own group.[205]

The goal of medicine as it confronts aging

> is not the extension of life as such, but the achievement of a full and natural life span. As it confronts aging, medicine should have as its specific goals averting premature death, understood as death before the

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[203] Callahan, *Setting Limits*, 204

[204] Callahan, *Setting Limits*, 204

[205] Callahan, "Is a Longer...," *Washington Post Health*, 6

> fulfillment of a natural life span, and the relief of suffering. It should pursue these goals in order that the elderly are able to finish out their years with a conviction that their lives have meaning and significance, with as little suffering as possible, with as much vigour as possible as they contribute to the welfare of the young and the community of which they are a part.[206]

In his understanding of old age Callahan has rejected a modernising view of aging which maintains that its physical processes should be aggressively resisted. The life-style of the aged must be transformed from past notions of disengagement and preparation for death to a continuing active involvement in the affairs of life and a persistent struggle against decay and death.[207] A modernising view of aging focuses on limitless possibilities and is committed to the use of medical knowledge to overcome the limits of aging. Aging is thus a new and exciting frontier, the beginning of a new life.[208]

Frequently Callahan contrasts the modernising view of aging to the common classical view of old age and to the view that prevailed in the nineteenth century. In the ancient world old age was considered to be superior to youth because of the maturity, wisdom and experience that comes with advanced years. In the last century, due to the rapid rate of social change, the future was judged to be best left in the hands of the energetic and adaptable young.

All three views of aging raise important questions as to the meaning and significance of aging in our society:

> In the absence of a public philosophy on the meaning of aging, any effort to limit or reduce resources for the elderly will, with some justice, be looked upon with suspicion - as a way of appearing to say, with behavior which belies words, that the old are simply not worth any further investment. . . If the elderly lack an established, coherent and meaningful place in life and society, there is no real rationale for their protection; it merely exists as a kind of sentimental beneficence. . . We lack, in the end, any penetrating social vision of the place of the aged.[209]

To give old age a real and substantive meaning a strong sense of continuity between past, present and future is required. Callahan is convinced that people must have a common conviction that old age is meaningful and significant. For him *meaning* refers to the interior perception, backed up by some specifiable traditions, beliefs, concepts or ideas, that one's life is purposive and coherent in its way of relating the

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206 Callahan, *Setting Limits*, 76-77

207 Callahan, *Setting Limits*, 26. See pp.27-31 for an analysis of Gerald Gruman's defence of modernisation.

208 Callahan, "Health Care...," *St.Louis University Law Journal*, 558

209 Callahan, *Setting Limits*, 32

inner self and the outer world - and even in the face of aging and death, it is a life which makes sense to oneself. *Significance* on the other hand refers to the social attribution of value to old age "that it has a sturdy and cherished place in the structure of society and politics, and provides a coherence among the generations that is understood to be important if not indispensible."[210]

Callahan does not require the understanding of the meaning and significance of old age to be full and perfect. Rather their importance for the elderly resides in them having a place in the wider community. Questions of meaning and significance are not to be relegated to private philosophical reflection. Rather society must seek to build, from the past and present, a renewed appreciation of the later years of life. Some of the new and more recently discovered possibilities of aging must be combined with valued ideas of older cultures, particularly those which saw old age as a time for reflective acceptance of decline and preparation for death.[211] In order to build this renewed understanding Callahan sets himself two tasks. The first is to discover or construct a social purpose for old age, the second is to gain a better understanding of the last stages of life in light of this social purpose.

Earlier societies and less developed societies today have operated with the belief that age brings not only wisdom but also the ability to interpret the moral traditions of the society. Secular first world communities have no generally binding moral traditions. As a result the elderly are unable to be a critical link in passing on the public tradition. They have no significant purpose in such societies since they have focused on accidental features of old age, namely free time, disposable income and post-retirement life-style pursuits. Callahan has accepted Thomas Cole's historical interpretation of aging and his portrayal of the influence the Calvinist tradition has had on modern views of old age.[212] The way forward, he argues, is by means of a reinvigorated theory of the life cycle.[213] Contemporary first world culture has repudiated the concept of the whole of life:

> A concept of a whole of life requires a number of conditions we seem reluctant to agree to: (1) that life has relatively fixed stages. . . (2) that death may present an *absolute limit* to life...(3) that old age is of necessity marked by decline and thus requires a unique set of meanings

[210] Callahan, *Setting Limits*, 33

[211] In this context it should be noted that Callahan critically evaluates *disengagement theory* first proposed in the 1950s. See Callahan, *Setting Limits*, 34-36

[212] Callahan, *Setting Limits*, 38-40

[213] In this he depends on the work of Erik Erikson.

> to take account of that fact...(4) that *our civilization* would be better off it it shared some common view of the *whole of life*. . .[214]

Erikson has emphasised the notion of integrity. The coherence and wholeness that comes with integrity is the most desirable trait of old age for it implies the finality in this stage of life. Life should be brought to a close in a thoughtful manner.[215] For Callahan the metaphor of time best illustrates this understanding. Elderly people not only capture the past in their memories and their story-telling but are also well qualified to show others how to live in the present. As regards the future, Callahan observes that "(t)heir indispensible role as conservators is what generates what I believe ought to be the *primary* aspiration of the old, which is to serve the young and the future."[216] Building on this insight he suggests that it is this seemingly paradoxical combination of withdrawal to prepare for death and an active, helpful leave-taking oriented toward the young which provides the possibility for meaning and significance in a contemporary context. Meaning is achieved because there is a purpose in aging of this sort. An identity for the self of the aging person is united with fulfilling a critical role in the lives of others, namely the linking of past, present, and future, something which, even if others are unaware of it, they cannot do without. Significance is provided because society, in recognizing and encouraging the aged in their duties toward the young, gives them a clear and important role, one that is both necessary for the common good and one that *only* they can play.[217]

Closely aligned with the meaning and significance of old age is the need for a vision "of what it means to live a decently long and adequate life, what might be called a natural life span."[218] The starting point for Callahan's reflection is the idea that an individual's death is recognised as natural when it is seen to accord with the prevailing cultural or religious model of human fulfillment.The difficulty for him, in American culture, is to determine what might be the appropriate models for the life course and a fitting death. The question is: "what should be an acceptable span of life and a tolerable death?"[219]

The notion of a *tolerable death* correlates with the concept of a natural life span. Death is *tolerable* when:

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214 Callahan, *Setting Limits*, 40-41

215 Erikson refers to this as the *grand-generative function* of old age.

216 Callahan, *Setting Limits*, 40-43

217 Callahan, *Setting Limits*, 43. The aspirations of the elderly to serve the young are outlined in some detail on pp.44-48

218 Callahan, "Aging...," in *Biomedical Ethics: An Anglo-American Dialogue*, 128

219 Callahan, *Setting Limits*, 66.

> (a) one's life possibilities have on the whole been accomplished; (b) one's moral obligations to those for whom one had had responsibility have been discharged; and (c) one's death will not seem to others an offense to sense or sensibility, or tempt others to despair and rage at the finitude of human existence. Note the most obvious feature of this definition: it is a biographical, not a biological, definition. A *natural life span* may then be defined as one in which life's possibilities have on the whole been achieved and after which death may be understood as a sad, but nonetheless relatively acceptable event.[220]

Callahan's use of the word *natural* in the phrase *natural life span* is an attempt to capture a cultural sense, expressed in ordinary language, of a *biographical* life, *not* a biological life. He focuses here on human experience and common modes of discourse and not on philosophical concepts. The language of a natural life-span is an attempt to articulate the particular cultural features common to a society. Callahan wishes to fashion his standard of limits from these cultural ingredients.[221] The notions a *natural life span* and a *tolerable death* are central to Callahan's public policy proposal for health care distribution to the elderly. This is to be discussed in chapter 5 in the context of the *age criterion* for health care. He believes, not without considerable criticism, that using age as a basis for limiting health care "can be a meaningful standard, that it can be a fair standard, and that it can be a standard that will much better than at present ensure an adequate distribution of resources between and among age groups."[222]

4.2.2.3 Dying and Death

Modern technological societies have witnessed a growing fear of aging and death. Increased technical intervention, particularly in life threatening and terminal situations, has contributed to a greater sense of risk and vulnerability among people. In addition the

> 'modern world . . . does not have a vernacular of fate. Cultures that live by the values of self-realization and self-mastery are not especially good at dying, at submitting to those experiences where freedom ends and biological fate begins.'[223]

220 Callahan, *Setting Limits*, 66. A detailed discussion of the natural life span definition is given in pp.66-76

221 D. Callahan, "Intolerable Necessity: Limiting Health Care for the Elderly", in *Facing Limits. Ethics and Health Care for the Elderly*, edited by G. R. Winslow and J. W. Walters, (Boulder, Co.: Westview Press, 1993), 9. This would appear to be a modification of his earlier use of the term, perhaps after the criticism of N. Jecker, "Appeals to Nature in Theories of Age-Group Justice", *Perspectives in Biology and Medicine* 33:4 (1990): 517-27.

222 D. Callahan, "Setting Limits: Medical Goals in an Aging Society" in *The Ethics of Care and the Ethics of Cure: Synthesis in Chronicity*, edited by J. Watson and M. A. Ray, (New York: National League of Nursing, 1988), 19

223 Callahan, *What Kind of Life?*, 253 where he quotes from an article by Michael Ignatieff

These factors have led Callahan to a detailed consideration of dying and death.[224] He is convinced that:

> [e]very great culture has had a characteristic view of death ordinarily accompanied by public rituals, customary practices, and time-honored patterns of communal grief. This understanding has provided those cultures with ways of interpreting death, consoling and supporting their members who are encountering it, and giving it a solid and public place in their people's everyday lives. Above all, they have related the question of death to other important categories of life, blending them into a more or less coherent whole. The most important among such categories, I believe, are the self, nature, society and medicine.[225]

His study on death provides a backdrop to some of the perspectives on aging already outlined. It gives a context to his *more austere thesis* regarding the allocation of health care resources to the elderly. Callahan considers in detail two particular bioethical issues related to dying. These will not delay us here beyond merely mentioning them. The first is the thorny issue of withdrawing food and fluid from dying persons.[226] The second is the much debated issues of assisted suicide and voluntary euthanasia.[227]

Medicine, Callahan argues, has lost its way with nature. In its struggle to combat illness and death medicine has come to confuse its power to alter, control or eliminate disease with its power to banish mortality. The result is a blurring of the dividing line between human powers and the powers of nature. Physical causality and moral responsibility, so elided, have resulted in a new tyranny in the human realm. Mortality itself is now our fault and our responsibility.[228]

To counter this Callahan elaborates an answer in terms of the notion *acceptable death*. Death is acceptable when it comes at the point in a life when:

> (1) further efforts to defer dying are likely to deform the process of dying, or when (2) there is a good fit between the biological inevitability of death in general and the particular timing and circumstances of that death in the life of an individual. This dual standard does not imply that there is a perfect moment for death to occur; that may be an unnecessary

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[224] "In a number of ways, I continue here the search I initiated in two earlier books, that of trying to understand how we should live with our mortality, and how medicine should help us to do so." Callahan, *The Troubled Dream of Life*, 21

[225] Callahan, *The Troubled Dream of Life*, 15

[226] Callahan, *Setting Limits*, 187-193; Cf. D. Callahan, "Feeding the Dying Elderly", *Generations* 10:2 (1985): 15-17.

[227] Callahan, *Setting Limits*, 193-197; Callahan, *What Kind of Life?*, 224-249; Callahan, *The Troubled Dream of Life*, 91-119

[228] Cf. earlier more detailed discussion of the link between medicine, technology and nature. See Callahan, *The Troubled Dream of Life*, 57-90

> fiction. It is necessary to think only in terms of death's falling within an acceptable range of possibilities.[229]

The acceptable death is neither biologically or morally wrong. It is no longer untimely or premature and the circumstances of the individual's death are commensurate with the respect we ought to pay to human life. The value should not be dependent on the the technological possibility of manipulating those circumstances. Callahan's goal is "to find a way of taking seriously in medical research and practice - which means also in the culture at large - the biological inevitability of death, which remains unaltered by scientific progress."[230] This understanding provides Callahan with the framework to develop concrete policies regarding termination of treatment, for suggesting contexts where a peaceful death might be possible, and for recognising when treatment is futile.[231]

4.2.3 Resource Allocation and Rationing of Health Care

The notions *allocation* and *rationing* assume that resources are limited.[232] For Callahan the *allocation* of health care resources refers to the place given to health care in the distribution of resources across a variety of social areas, including education, housing, defence etc. *Rationing*, by contrast, involves making distinctions within a particular category, such as health care, deciding which needs are comparatively more or less important and should be dealt with first.[233]

Callahan on a number of occasions has referred to the fact that cost cutting methods have failed in American health care.[234] He goes so far as to say that "(n)ot one of the major cost-containment initiatives has yet succeeded - or shows any serious promise

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229 Callahan, *The Troubled Dream of Life*, 180

230 Callahan, *The Troubled Dream of Life*, 184

231 See Callahan, *The Troubled Dream of Life*, 209-219

232 D. Callahan, "Symbols, Rationality and Justice: Rationing Health Care", *American Journal of Law and Medicine* 18 (1992): 3

233 Callahan, "Meeting Needs...," *Law, Medicine and Health Care*, 261. He further distinguishes soft rationing (that which occurs in a casual and unsystematic way under the market system) from hard rationing (where choices are openly specified and one possible health good is chosen rather than another).

234 The three main cost-containment measures used are (1) encouragement of competition, (2) the promotion of health maintenance organisations (HMOs), and (3) the control of hospital reimbursements under Medicare, especially by means of diagnosis related groups (DRGs). Callahan, *What Kind of Life?*, 76-77. Cf. S.M. Shortell, R.R. Gillies and K.J. Devers, "Reinventing the American Hospital", *The Milbank Quarterly*, 73 (1995): 131-160

that it will eventually succeed."[235] He believes that a shift in fundamental values must accompany any effective and stringent cost-cutting moves. It is not a matter of "either/or" but of "both/and".[236] The shift in values is a philosophical task. People must "be prepared to live with a less ambitious view of medical progress, and a less soaring vision of the liberation of human beings from illness, decline, and death."[237]

Not everyone agrees with Callahan's conviction that a problem exists in health care, especially the delivery of that care to the elderly. In *Setting Limits* he examines four critiques of his thesis. The first argues that the heterogeneous character of the elderly makes it almost impossible to make projections about their future. Furthermore, to make projections about the future, extrapolating from present data as though it were an accurate picture, does not take account of the many variables involved.[238] The second set of criticisms argues that present expenditure on health care as a proportion of the GNP is not a magical figure. It could well go higher or lower. Some would argue that, because there are many areas for cutting costs in health care delivery, talk of rationing is premature.[239] The third set of counter-arguments Callahan characterises in terms of "guns or canes?" If so much money is being spent on national defence, tobacco products, even a football T.V. commercial, why should money spent on the sick and the elderly be rationed? Callahan acknowledges the potency of this argument:

> The lack of any coordinated health, welfare, and social planning means that each group has powerful incentives to pursue its own interests, even if it is known that other valid interests exist . . . There thus seems to be no good reason for any one group to forgo its demands and needs in favor of other groups, at least if the motive is to help the other groups.[240]

The fourth argument against rationing health care for the elderly holds that because everyone either is already old or will become old, a social policy of expenditures on the elderly benefits all generations in the long run. This is our common stake. Furthermore, health-care benefits for the aged have some immediate value for

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235 D. Callahan, "Allocating Health Resources", *The Hastings Center Report* 18:2 (1988): 14. See also D. Callahan, "Elderly Health Care: There Ought to be a Limit", *U.S. Catholic* 53:7 (1988): 14

236 D. Callahan, "Rationing Medical Progress. The Way to Affordable Health Care", *The New England Journal of Medicine* 322:25 (1990): 1812

237 Callahan, "Setting Limits...," in *Ethics in Medicine*, 57

238 Callahan, *Setting Limits*, 120-123

239 Callahan, *Setting Limits*, 124-126

240 Callahan, *Setting Limits*, 127

younger generations. They help relieve the young of burdens of care for the elderly they would otherwise have to bear.[241]

One particular response to escalating health care costs has been to target the expenditure on the dying elderly. Referring to the claim that about one percent of the GNP is being spent on health care for elderly persons in the last year of their lives Callahan has argued for a disentangling of the issues involved in the claim. First, empirical evidence must be presented proving that substantial savings will be made should expensive care be withheld from the elderly dying. Second, even if large amounts of money are spent on the dying elderly, is it an unreasonable and unjust amount?[242] Callahan acknowledges the complexity of the problem yet disagrees that substantial savings can be achieved. He does accept, however, that the aged are going to be an expensive group to care for simply because they are elderly. But he sees no *prima facie* argument that the expenditure on such patients is unreasonable and wasteful.[243] These arguments indicate an

> animus against rationing in the United States, symbolically and literally, [which] expresses in one sense some of our most admirable values. Those are our touching faith in the power of efficiency, our commitment to egalitarianism, and our reluctance officially to pick upon the poor to test our social schemes. Rationing is thought to offend all of those values and thus is rejected.[244]

In addition to specific anti-rationing pressures a further set of difficulties makes attaining a just health care system extremely difficult. They have been discussed earlier and ought be brought to mind at this point. The first difficulty in allocating health care resources derives from the fact that no logical or conceptually specifiable stopping point can be discerned since the logic of technical progress endlessly redefines need. The second problem arises from the fact that technological means are used that themselves admit of no inherent technical or economic boundaries. Third, use of technology is founded on a moral imperative which views the causes of illness and death as evils that must always be overcome.[245]

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[241] Callahan, *Setting Limits*, 128. See also Callahan, "Meeting Needs...," *Law, Medicine and Health Care*, 263

[242] Callahan, *Setting Limits*, 130-131

[243] Callahan, *Setting Limits*, 132-133

[244] Callahan, "Symbols...," *American Journal of Law and Medicine*, 12-13

[245] Callahan, "Transforming Mortality...," *Southern California Law Review*, 219-220

4.3 SUMMARY AND CONCLUSIONS

4.3.1 Summary

Chapter 4 outlined the conceptual frameworks that Norman Daniels and Daniel Callahan have adopted in addressing the issue of just health care for the elderly. Each author represents a particular school of thought regarding society and justice. Daniels proposes a liberal approach, Callahan operates within a communitarian framework. Norman Daniels takes an *atomist* view of social life and applies a Rawlsian account of justice to the issue of health care for the aged. He argues that health and health care are special and that justice-as-fairness offers a satisfactory framework for resolving the dilemmas generated by health care in an aging population. His explanation hinges on a principle of *fair equality of opportunity* regarding the social good of health care and depends on a *prudential lifespan account* where goods to be distributed are computed over the human life-time.

Daniel Callahan adopts a *social* or communitarian approach to the issue of just health care for the aged. His approach operates at two levels. At a *philosophical level* Callahan criticises the ethos of American society and its "minimalist ethic"; in its place he urges Americans to accept the reality of human limits. At the *policy level* Callahan gives priority to *care* over *cure*. Central to his argument regarding health care for the aged is an understanding of the *natural life span* and the notion of a *tolerable death*. In the light of this Callahan proposes a public policy which sets an age limit to publicly funded, high technology, life-extending therapies.

4.3.2 Conclusions

The exposition in chapter 4 makes it possible to conclude that

Norman Daniels

1. makes a significant contribution to the issue of just health care for aged persons with his emphasis on liberal values such as autonomy, fairness and equality of opportunity and his acceptance of the role of the human lifespan in evaluating just distribution of limited resources.

2. His approach is too formal, making it of little practical use. It is also inadequate since, because of its narrow focus on justice, he ignores the humanistic dimensions of the human undertaking at the heart of this thesis.

Daniel Callahan

1. makes a more satisfactory attempt than Daniels especially in the attention he gives to wider philosophical and policy perspectives of the topic. The priority he gives to the historical and community dimensions of individual and societal life, however, makes his contribution to the literature an important one.

2. His presentation is discursive and as a result somewhat diffuse. This has contributed to the confusion evident in the literature. Furthermore, Callahan uncritically presumes the framework of American liberal democracy and does not appear to recognise that this is a factor limiting the overall value of his work.

CHAPTER 5

TWO PROPOSALS FOR JUST HEALTH CARE FOR THE AGED

5.1 Age as a Criterion for Health Care Distribution 232

- 5.1.1 Daniels on the Age Criterion 232
- 5.1.2 Callahan on the Age Criterion 235
- 5.1.3 Critical Issues 238
  - 5.1.3.1 Equity and Intergenerational Relations 238
  - 5.1.3.2 Lifespan and Intergenerational Relations 240
- 5.1.4 Evaluation of the Age Criterion Proposal 242
  - 5.1.4.1 Callahan's Argument 242
  - 5.1.4.2 Daniels' Account 245

5.2 Intergenerational Obligations and Health Care 247

- 5.2.1 Daniels and Obligations Between the Generations 247
- 5.2.2 Callahan on Intergenerational Obligations 250
- 5.2.3 Evaluation of the Contribution of Daniels and Callahan 257
  - 5.2.3.1 Myths, Families and Elderly Parents 257
  - 5.2.3.2 The Ethical Struggle with Intergenerational Obligations 259

5.3 Summary and Conclusions 262

- 5.3.1 Summary 262
- 5.3.2 Conclusions 263

CHAPTER 5

TWO PROPOSALS FOR JUST HEALTH CARE FOR THE AGED

Chapter 4 has provided a detailed account of the work of Norman Daniels and Daniel Callahan on issues of justice, health care and aging. This chapter critically evaluates the manner in which they address the issue of just health care for the elderly. The decades following the Second World War brought an unprecedented expansion of material goods, technological innovation and general prosperity to American society. The global oil crisis of the early 1970s and the failure of American involvement in the Vietnam war ushered in a period of uncertainty and crisis for an industrial society which had experienced sustained growth and success for many years. The pervasive values of this society have been set out in Callahan's critique of the American ethos. Confronting the experience of limits had a shock effect on the national psyche.

This *limits-experience* influenced the discussions of justice and health care by focusing on two problem areas which Daniels and Callahan have pursued in some detail. The first concerned a proposal put forward by Callahan that an age criterion for access to health care might be a viable public policy initiative in a world of limited resources and ever increasing demand. The second issue has wider philosophical and practical implications: the obligation adult children have to provide care for aging parents. Smaller and more mobile families, larger numbers of women in paid employment, restricted accommodation and finance are but some of the factors that have changed and limited what contemporary families are able to offer to parents. These social changes parallel increasing longevity, illness and disability in old age and are among a number of factors affecting larger numbers and a growing proportion of the population. This has placed increasing strains on adult children and on the fabric of contemporary family life. Increasingly the state has had to shoulder responsibility for a range of supportive resources for the elderly. This social burden has provoked calls for generational equity in a society where elderly people have considerable political and economic clout. Advocates of generational equity point to the relatively secure place the elderly have vis-a-vis children and the poor and to the fact that working people must bear an unfair economic burden.[1] It is within this wider social context that Daniels and Callahan analyse the issue of justice and intergenerational obligations.

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[1] Daniels, *Am I My Parents' Keeper?*, 4-6

Chapter 5 develops in two parts. In the first part attention is paid to the proposal that age be a criterion for just distribution of health care to the elderly. Intergenerational obligations are analysed in part two. Both sections include an exposition of each author followed by a critique of their differing approaches.

5.1 AGE AS A CRITERION FOR HEALTH CARE DISTRIBUTION

5.1.1 Daniels on the Age Criterion

Daniels developed his approach by first distinguishing between *age groups* and *birth cohorts*. The notion *age group* refers to people who fall within a certain age range or are at a certain stage of life. A *birth cohort*, on the other hand, refers to a distinct group of people who have a distinctive history and composition. Age group abstracts from the distinctive nature of the birth cohort and views people solely in reference to their place in the lifespan. This permits Daniels to argue that the question:

> about justice between age groups also abstracts from the particular differences between the current elderly and the current young that arise because of the distinctive features of the birth cohorts which happen to make up those age groups. We are concerned with a common problem about justice between the old and the young that persists through the flux of aging birth cohorts.[2]

Age groups coexist, cooperate and compete in the same political and moral setting. Future generations, on the other hand, are at the mercy of the current generation.[3] An age criterion functions differently to appeals made on the grounds of sex or race. The age criterion operates *within* a life and not *between* lives as do criteria of sex and race:

> Rationing by age criteria *looks like* a case of crossing personal boundaries *only if we take a 'time slice' perspective*. Once we take the perspective of institutions operating through time, the appearance of crossing boundaries between persons fades and we are concerned

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2 Daniels, *Am I My Parents' Keeper?*, 13

3 Daniels, *Am I My Parents' Keeper?*, 15. Daniels sees the relationship of present to future generations as quite different to the relationship between present young and old cohorts. "The major difference is that young birth cohorts are transformed in time into elderly cohorts: they age. But no current generation becomes a future generation....A further difference between the aging and future generations problems is that different age groups coexist and compete politically for social goods distributed in cooperative arrangements. Future generations are not here to fight for their interests." Daniels, *Just Health Care*, 95

> primarily with distribution through the stages of life. No comparable point is true for rationing by race or sex over time.[4]

The distribution of resources between age groups has taken on a new character in our time. It is only in this century that society has assumed direct responsibility for transferring certain goods and services from the young to the old. When the responsibility for these transfers resided with families, as it still does for long-term care, the age-group problem seemed to be an individual or family one and not a matter of social justice. It was couched in terms of family obligations, not requirements of justice. The age-group problem remained hidden until the aging of society sharpened conflicts about the social obligations to transfer these resources.[5]

In a number of places Daniels refers to the practice in the British National Health Service of rationing by age. He has defended the view that pure age-rationing is morally permissible under certain, very specific and restrictive conditions. His defence is articulated in prudential and non-prudential terms. The prudential account, which has been outlined earlier, uses the Rawlsian original position framework. Deliberators operate behind a veil of ignorance that limits their decision-making to issues concerning the transfer of goods within a lifespan. Saving resources so that the elderly have claim to them in their later years is possible only if access to them is reduced in the earlier stages of life. "A central effect of this form of saving is that we increase our chance of living a longer-than-normal lifespan at the cost of reducing our chances of reaching a normal lifespan."[6] This version of the prudential argument maintains there are conditions under which a health-care system that rationed life-extending resources by age is the prudent choice and, therefore, the choice that constitutes a just and fair distribution of resources between age groups.[7]

Daniels' non-prudential argument considers the anti-age-rationing argument that appeals to equality. A scheme favouring rationing by age will not treat a 75 year old person the same as a 55 year old even though there may be no difference in their medical condition or need. Many consider this to be morally objectionable. This approach makes two distinct claims - one about equality and the other about moral relevance. In reference to the question of equality Daniels' prudential lifespan account has argued that the 75 year old person and the 55 year old one will not be treated differently over the course of their lives. Thus treating someone at 75

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4 Daniels, *Just Health Care*, 97

5 Daniels, *Just Health Care*, 12

6 Daniels, *Am I My Parents' Keeper?*, 86-87

7 Daniels, *Am I My Parents' Keeper?*, 91

differently from someone now 55 does not constitute unequal treatment of the person over his or her lifetime.[8]

Daniels' approach is liable to two criticisms which he does, in fact, consider. The first analyses the argument in favour of rationing which appeals to equality or fairness in a different way. It argues that priority should be given to the young for health care services. The old have had their chance to live more years and it is only fair to the young to give them an equal chance. Daniels rejects this appeal to the intuition of fairness. He argues that his approach does not rely on prior intuitions about fairness. Rather, the "fairness of the outcomes - what counts as just is what prudence recommends under these choice conditions - is derived from the fairness of the choice and the fact that it is reasonable for us to let these deliberators decide for us."[9] The second criticism levelled at Daniels' approach claims that life has equal value at any age. This *equal worth* argument is often coupled with the complaint that no one other than the person whose life is in question should judge its worth. Daniels replies by noting that his approach does not entail one person's judgments about the value or worth of another person's life. Rather, "it involves persons making judgments *for themselves* about benefits *to themselves* at different stages of their lives."[10]

Repeatedly Daniels has rejected the claim that the prudential argument, in general, sanctions rationing by age. Rather, "such justification is possible only under very special circumstances."[11] Daniels imposes three conditions for the age criterion's use. First, the age criterion may only be appealed to as part of the design of a health care system that distributes resources over the lifetime of the individuals it affects. Second, his argument must not be viewed as a convenient cost constraining device in the context of current debates regarding health care delivery. Third, Daniels' argument is part of an *ideal theory of justice* in which general compliance with principles of justice that govern other aspects of the basic social institutions is assumed. "The argument does not readily or easily extend to nonideal contexts, in which no such compliance with general principles of justice obtains."[12]

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8 See Daniels, *Am I My Parents' Keeper?*, 98-102 where Daniels discusses the moral relevance of age in distributive contexts.

9 See Daniels, *Am I My Parents' Keeper?*, 93

10 Daniels, *Am I My Parents' Keeper?*, 94. Daniels notes that there are many examples of the age-rationing argument that claims ("their") elderly lives are not worth what ("our") younger ones are. Methods of pricing life, such as QALYs, function on the basis that "there is a better return on the social investment of resources if the young get treated and the old do not."(*ibid.*, 94)

11 Daniels, *Am I My Parents' Keeper?*, 96

12 Daniels, *Am I My Parents' Keeper?*, 96

5.1.2 Callahan on the Age Criterion

Whereas Daniels responds to the challenge of limits in health care delivery by arguing from within a justice-as-fairness framework for the preeminence of the individual prudent deliberator making decisions over a life time, Callahan's proposal for an age criterion demands a social consensus on health care, the natural life span and the scope of government obligations.

In an effort to stipulate limits to health care for the aged Callahan requires that certain important preconditions to be met: (1) the establishment of national health insurance; (2) a greatly improved program of long-term and home care, with a better balance between caring and curing; (3) greater efforts to improve the daily quality of life of the elderly; (4) government limitations on health care to be restricted to federal entitlement programs such as Medicare; and (5) limits to be applied only to expensive high-technology medicine.[13] Should these preconditions be established how might limits be set for the provision of health care? In attempting his answer Callahan has strongly rejected the standard of individual benefit such as treatment outcome.[14] This, he has argued, must not be used with the elderly:

> It would be unfair, not necessarily affordable, and beg a number of questions about what we owe the elderly. More broadly, if limits are to be set I do not think that it can be done on a case-by-case basis.[15]

The only alternative is the use of *categorical* limits. These are "visible, objective, universal criteria that can be applied to all (or most) individuals and that do not require complex interpretation to be employed."[16] Such categorical limits must apply to everyone equally, threaten everyone alike and be useable in a simple and straightforward way.[17] Deciding what should be regarded as a *reasonable* claim to

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13 Callahan, "Intolerable Necessity...," in *Facing Limits*, 5

14 There has been no single and consistent basis for health care for the elderly in the welfare state approaches of recent times. "The ideas of veteranship, of earned merit, of need, or respect for age as such, and various pragmatic motives have all played a part in different societies and in our own as well." Callahan, *Setting Limits*, 134

15 Callahan, "Intolerable Necessity...," in *Facing Limits*, 6-7. Callahan argues that rationing by individual decisions in the clinical situation is conceptually incoherent, professionally unacceptable and economically ineffective. Callahan, "Rationing Health Care...," *Issues in Law and Medicine*, 357-359

16 Callahan, "Rationing Health Care...," *Issues in Law and Medicine*, 354. Callahan did toy with the possibility of flexible (i.e. the doctor decides if a patient fulfills the published criteria) as against fixed categorical standards (*ibid.*, 360-362). See also D. Callahan, "Setting Limits: Daniel Callahan Responds", *St.Louis University Law Journal* 33:3 (1989): 707-10; D. Callahan, "Must the Old and Young Compete for Health Care Resources?", *Neurosurgery* 27:1 (1990): 163

17 Callahan, "Intolerable Necessity...," in *Facing Limits*, 7

health care makes Callahan's rationale analagous to the argumentation proposed by Norman Daniels. For Callahan:

> the idea of a *natural* life-span plays the same kind of role, but at a conceptual level, that global budgeting does at the economic level. Each allows us to establish a boundary, to have a common and understandable way of saying *no*. The line I think most plausible to draw to establish that boundary is that of age itself, and age calculated by thinking about the human life-cycle.[18]

Callahan is able to take this step by limiting the parameters of human need. As noted earlier in chapter 4 he rejects both an open-ended understanding of need and the nexus that has been established between medical need and technological possibility. He defines "need in the old as primarily to achieve a natural life span and thereafter to have their suffering relieved."[19] By explaining it in this way a general and socially established ideal of old age is achieved:

> We owe each other a long and decent life, a full life, but it is unreasonable for anyone to claim as long a life as might be theoretically possible regardless of the cost. Put another way, we owe each other a *natural* life-span, not immortality.[20]

Callahan's natural life span differs from Daniels' *normal opportunity range*. For Daniels the normal opportunity range functions as a statistical criterion in his lifespan account. It should, however, be given a normative meaning and thus would indicate what counts as morally and socially adequate and generally acceptable. This is the sense in which Callahan uses the expression *natural life span*. He is convinced it is morally defensible to employ it in this way for developing policy. A natural life span can be attained within a roughly specifiable number of years. Furthermore, it is relatively impervious to technological advances. The primary aim is to try to bring everyone up to this standard, leaving any decision to extend life beyond that point as a separate social choice. Callahan rejects the latter course of action whether resources are available or not.[21]

How does the criterion of age function in the allocation of resources debate? Callahan has opposed the use of age as a medical criterion, treating chronological age as if it were equivalent to other physical characteristics of the patient. Rather, he views age as a *person-centered* characteristic. This is the *biographical* standard implied in the age criterion that has generated great discussion and criticism. Callahan considers that his view of age as a biographical criterion makes it possible

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18 Callahan, "Intolerable Necessity...," in *Facing Limits*, 8

19 Callahan, *Setting Limits*, 135

20 Callahan, "Intolerable Necessity...," in *Facing Limits*, 8.

21 Callahan, *Setting Limits*, 137

to formulate principles for terminating aggressive treatment to dying patients. He proposes three principles. (1) After a person has lived out a natural life span, medical care should no longer be oriented to resisting death. No precise chronological age can readily be set for determining when a natural life span has been achieved since biographies vary but it would normally be expected by the late 70s or early 80s.[22] (2) Provision of medical care for those who have lived out a natural life span should be limited to the relief of suffering.[23] (3) The existence of medical technologies capable of extending the lives of the elderly who have lived out a natural life span creates no presumption that the technologies must be used for that purpose.[24]

On the basis of this understanding as to how curative treatment might be limited where the elderly are concerned Callahan puts forward three principles for an allocation policy in society.[25] Government has a duty (1) to help people live out a natural life span, but is not obliged to extend life by medical means beyond that point; (2) to develop, employ and pay for only that kind and degree of life-extending technology necessary for medicine to achieve and serve the end of a natural life span; (3) to provide relief of suffering for persons who have reached their natural life span.[26]

The treatment proposals and allocation criteria articulated by Callahan were intended to stir national debate.[27] The "real, and ultimate, limits I am proposing are on unlimited medical progress" with a cut off somewhere around the age of 80, "five years *beyond* our average life expectancy at present."[28] Callahan has sought consistently to limit the increase in the cost of medical treatment for the elderly, not to cut the elderly off from medical treatment.

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22 More recently Callahan writes: "In my book, I left open the question of what that age might be. I said, probably the 'late 70s or early 80s'. But what I really wanted to convey by that indeterminacy was the necessity of reaching a public consensus. This is a standard we would put together as a people, young and old, not one to be unilaterally imposed by government..." Callahan, "Intolerable Necessity...," in *Facing Limits*, 10. In another article Callahan speaks of a *cultural standard*. "We now have cultural traditions and some common expectations that can be built upon to fashion such a standard. I begin with our common understanding of what is meant when we speak of someone having lived a full life, something we typically say of a person who has died in old age." Callahan, "Health Care...," *St.Louis University Law Journal*, 565

23 Callahan acknowledges he is impressed by the philosophy of the National Health Service in the U.K. Callahan, "Aging...," in *Biomedical Ethics: An Anglo-American Dialogue*, 130

24 Callahan, *Setting Limits*, 171-173

25 Callahan, "Rationing…," *Issues in Law and Medicine*, 362

26 Callahan, *Setting Limits*, 137-138. See also Callahan, "Health Care...," *St.Louis University Law Journal*, 557-68.; Callahan, "Rationing…," *Issues in Law and Medicine*, 353-66

27 Callahan, D. "Setting Limits...," *St.Louis University Law Journal*, 710

28 Callahan, "Intolerable Necessity...," in *Facing Limits*, 12

5.1.3 Critical Issues

Much of the discussion on rationing and health care distribution arises from a concern with the present and future demographic profiles of first world countries. Sociologists use the concept of *disordered cohort flow* to describe substantial differences in adjacent birth cohorts. As the baby boom generation ages the characteristics of succeeding cohorts vary dramatically leading to shifts in age distribution that place stresses and strains on existing social structures.[29]

5.1.3.1 Equity and Intergenerational Relations

Since the late 1970s preoccupation with the relationship between generations has contributed to an intense debate regarding the U.S. Social Security and Medicare systems. Both federal programs have been blamed for the deteriorating condition of children and families. The so called *greying* of the federal budget to the financial advantage of the aged has generated, it is claimed, great disparities within American society.[30] Since 1985 an advocacy group called Americans for Generational Equity (AGE) has argued that other groups, especially women from minority groups and children, have suffered because of the financial advantages enjoyed by the elderly.[31]

At present Australia does not mirror what has occurred in the U.S.A. The Australian social welfare, Medicare and unemployment benefits systems differ markedly from what prevails in the U.S.A. A stronger emphasis on social justice policy in the

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[29] V. L. Bengtson and D. Dannefer, "Families, Work, and Aging: Implications of Disordered Cohort Flow for the Twenty-First Century" in *Health in Aging. Sociological Issues and Policy Directions*, edited by R. A. Ward and S. S. Tobin, (New York: Springer, 1987), 256-89. The authors discuss the disordered cohort flow and its implications on work and the family against the background of four futurist scenarios: continued growth, decline and stagnation, disciplined society, transformed society. It is relevant here to register scepticism regarding the use of "birth cohorts" in discussions of equity issues. "We can't really define the boundaries of a cohort. Therefore, the concept of a cohort is incoherent and unworkable for puposes of policy analysis." H. R. Moody, "Generational Equity and Social Insurance", in *Ethics in an Aging Society*, (Baltimore: The Johns Hopkins University Press, 1992), 209

[30] E. R. Kingson, B. A. Horshorn and J. H. Cormann. "Intergenerational Inequity: Why It Won't Work As a Framework for Policy" in *Ties That Bind. The Interdependence of Generations*, (Washington, D.C.: Seven Locks Press, 1986), 130. The intergenerational inequity argument reflects beliefs such as the following: (1) Programs for the elderly are a major cause of current budget deficits and economic problems. (2) The elderly receive too large a portion of public social welfare expenditures to the detriment of children and other groups. (3) Because of demographic trends the future costs of programs for the elderly will place an intolerable burden on future cohorts of younger workers. (4) Younger people will not receive fair returns on their Social Security and Medicare investments.

[31] Generational equity is "the notion that all generations and all age-groups have a right to be treated fairly, that we cannot advocate for benefits for the elderly without considering the competing rights and claims of other age-groups." Moody, "Generational Equity...," *The Journal of Medicine and Philosophy*, 31

political arena appears to have operated in this country at both the federal and state levels. Nevertheless a number of trends give cause for concern. Economic rationalist forces in government focus intently on costs, employment and productivity. The liberal emphasis on the individual exemplified in workplace agreements, restricted eligibility for pensions and social welfare, and constantly changing superannuation policies have long-term implications for future care of the aged.

Proponents of intergenerational inequity in the U.S.A. frame policy issues in terms of competition and conflict between young and old over the distribution of resources. A narrow understanding of fairness joined to a restrictive measuring of transfers of selected resources between generations are proposed as determinants of fair public policy. Frequently, benefit transfers are considered at only one point rather than over an extended period of time.[32] Claims that intergenerational arrangements are unfair ignore, therefore, the common stake all have in society and its policies for the elderly. Many direct and indirect benefits flow throughout society when the aged are cared for. For that reason the notion of a *dependency ratio* between old and young must be used critically.[33] Elderly people are a diverse group, even economically, and any reduction of public expenditure on them will have private costs.[34]

Proponents of intergenerational equity have depended on a thin, analytical conception of liberty as individual autonomy. The more humanistic conception of equity to be found in continental philosophy and theological ethics suggests that equity between generations requires a shift in the current emphasis from the individual to the community, "from *in*dependence to *inter*dependence, from demand to gift, from *self*-fulfillment to sacrifice, and from generational *conflict* to generational *cooperation*."[35] A better understanding of the challenges implicit in an aging society develops when the common stake all generations have in intergenerational transfers is recognised.[36] Over the course of their lives individuals both give and receive care within their families. Social security is an excellent example of the way benefits and burdens are widely distributed through intergenerational transfers. Not only economic transfers, but transfers of knowledge and culture are essential to each generation's progress and continuity. European

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32 Kingson, Horshorn and Cormann. "Intergenerational Inequity...," in *Ties That Bind*, 131

33 Cf. R. L. Sprott, "Policy Implications and Ethical Dilemmas Posed by an Aging Population" in *Life Span Extension. Consequences and Open Questions*, edited by F. C. Ludwig, (New York: Springer, 1991), 120-31

34 Kingson, Horshorn and Cormann. "Intergenerational Inequity...," in *Ties That Bind*, 131

35 S. Sapp, "Ethical Issues in Intergenerational Equity", *Journal of Religious Gerontology* 7:4 (1991): 10

36 Kingson, Horshorn and Cormann. "Intergenerational Inequity...," in *Ties That Bind*, 161

thinkers defend a *humanitarian solidarity* that attends to the needs of all groups. This solidarity has undergone considerable change nonetheless. The *mechanical* solidarity of class and neighborhood has given way to a new dependency on the bureaucratic structures of the state and other social institutions (for example, insurance companies). Instead of the personal relations that were dominant in traditional society (horizontal dependency), individuals are nowadays dependent on each other through collective arrangements of the state (vertical dependency). These arrangements safeguard individuals against the uncertainties of human existence such as those resulting from natural causes (disease, handicaps) or social ones (loss of income). Nowadays, solidarity is *organic*, in Durkheim's terms, and involves sharing the financial risks of illness and handicap with others not necessarily of one's own social group.[37] When common loyalty and solidarity for the common good are lacking society underwrites "the care of the old and the young under the assumptions of an *ethics of strangers*, of people who share no common life and are bound by no ties of sentiment or confidence."[38]

Daniels and Callahan have developed their thinking in a society where intergenerational concerns have been significant. They have avoided the narrow assumptions implicit in the claims of intergenerational inequity.[39] Daniels' entire life-time perspective has recognised the need to view health care distribution more comprehensively. Callahan likewise avoids competition between old and young by making the natural life span the criterion for deciding what is owed and to whom it is owed. It is to the concept of the natural life span that attention must now be given.

5.1.3.2 Lifespan and Intergenerational Relations

A significant thread throughout the debate about distribution of benefits and burdens between generations is the lifespan paradigm. Both the communitarian Callahan and the liberal-Rawlsian Daniels use the lifespan (or life cycle or life course) as a fundamental unit of analysis. They turn, with differing emphases, to this universal

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[37] R. ter Meulen, "Are There Limits to Solidarity with the Elderly?", *The Hastings Center Report* 24:5 (1994): 36. Harry Moody refers to this organic solidarity as a "network of publicly visible practices or institutions" manifesting an "intergenerational compact". H. R. Moody, "Intergenerational Solidarity" in *Ethics in an Aging Society*, (Baltimore: The Johns Hopkins University Press, 1992), 230

[38] Moody, "Intergenerational Solidarity" in *Ethics in an Aging Society*, 239

[39] Meredith Minkler has failed to appreciate this when she argues that Callahan "reverts in part to the same spurious 'generational equity' arguments: Society must 'set limits' on care for the elderly partly so that more of its resources can be used to benefit the young." M. Minkler, "Generational Equity and the Public Policy Debate: Quagmire or Opportunity?" in *A Good Old Age? The Paradox of 'Setting Limits'*, edited by P. Homer and M. Holstein, (New York: Simon & Schuster, 1990), 222-39

category as a way of overcoming the divisiveness arising from a too narrow concentration on age-groups, cohorts, or generations.

Daniels' *prudential lifespan account* encourages individuals to think that they are saving or insuring themselves against the vicissitudes of old age and disability. The primary justification for support or care for the elderly derives not from intergenerational obligations but from the equal opportunity to pursue one's own life plan at every stage of life. Prudence leads people to support programs not out of commitment to a common good but because of a situation in which all have a common stake. In a society characterised by mass longevity, a life course perspective can encourage a kind of solidarity between age groups.

Callahan differs in his use of the natural life span. For him the concept of the natural life span is an attempt to articulate cultural features common to a society. For that reason it is the notion of a biographical life, not a biological one that dominates. Human solidarity is grounded in the shared humanity of persons in society.[40]

Beyond questions of distributive justice between young and old there exists, within the intergenerational debate, a concern for future generations. An obvious concern is that public institutions will fail to deliver, in the near future, promised benefits when those who are presently young become old. Philosophical literature in the English speaking world has touched briefly on the obligations we have to future generations.[41] Responsibility for future generations has been analysed in a variety of ways with no one theory being totally satisfactory.[42] A resolution of the conflict between generations who are nearer (or present) and those more distant has yet to be

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40 Thomas Cole observes that "the moral economy of the life course, then, forms the unspoken historical context of both Daniels' and Callahan's views about justice between the young and the old in an aging society. Both are aware of the need to rethink the moral obligations between age groups and to reformulate the moral economy of the lifespan in a new demographic context. Yet neither fully appreciates how much has been lost by secularization and modernization of the life course." T. R. Cole, "Generational Equity in America: A Cultural Historian's Perspective", *Social Science and Medicine* 29:3 (1989): 380

41 M. P. Golding, "Future Generations, Obligations to" in *Encyclopedia of Bioethics*, edited by W. T. Reich, Vol. 2, (New York: Free Press-Macmillan, 1978), 507-12; R. M. Green, "Justice and the Claims of Future Generations" in *Justice and Health Care*, edited by E. E. Shelp, (Dordrecht: D. Reidel, 1981), 193-211; B. G. Norton, "Future Generations, Obligations to" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 2, (New York: Simon & Schuster Macmillan, 1995), 892-99. Peter Singer in his review of Callahan's *Setting Limits* explored the nature of the benefits that might result for future generations as a result of present efforts to set limits. Singer, "Review Essay", *Bioethics*, 151-69

42 Theories of responsibility utilise a utilitarian calculus, a Rawlsian "just savings" principle, Passmore's "chain of loves" down the generations. Golding elaborates an understanding of the moral community with its common commitment to a social ideal. Golding, "Future Generations...," in *Encyclopedia of Bioethics*, 508-510

proposed. It would seem that it is only possible to argue that the present generation accept responsibility for a number of basic goods such as air, water, and sources of nourishment which are passed on as entitlements to future generations.[43]

5.1.4 Evaluation of the Age Criterion Proposal

5.1.4.1 Callahan's Argument

Daniel Callahan views the age criterion in the context of a social value system which must recognise *reasonable limits*. Norman Daniels, on the other hand, with his eye on the prudent deliberator, emphasises that it is the *reasonable thing to do* to implement limits to health care for the elderly.[44] Both approaches must now be critically assessed.[45]

Callahan's central claim is that there is a natural end to the lifespan.[46] Medical resources should be used to get people up to the natural completion point. After that the elderly have a right only to comfort and inexpensive treatments for acute illness.[47] It follows from this that medical care needed to complete the major phases of the life cycle generates a higher moral claim than the care required to sustain life after the life cycle has been completed. According to Callahan the "old should step aside in an

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[43] D. Callahan, "What Obligations Do We Have to Future Generations?", *American Ecclesiastical Review* 164(1971):265-280; Green suggests a rough rule of thumb to guide inter-generational moral thinking: "we are required to strive to ensure that our descendants are left with the means to a progressively better quality of life than ourselves and, at a very minimum, are not rendered worse off by our actions." Green, "Justice...," in *Justice and Health Care*, 198

[44] D.W. Brock supports Daniels' account and maintains that "individualist liberalism remains our best guide to the age group problem." D. W. Brock, "Health-Care Entitlements and the Elderly: A Liberal Critique of 'Setting Limits'" in *A Good Old Age? The Paradox of 'Setting Limits'*, edited by P. Homer and M. Holstein, (New York: Simon & Schuster, 1990), 140-53. Despite the differences between Callahan and Daniels, Brock argues "that central parts of what is most interesting and plausible in each's view are compatible and that not losing sight of them will yield a richer and deeper public debate about health care for the elderly." D. W. Brock, "Justice, Health Care, and the Elderly", *Philosophy and Public Affairs* 18 (1989): 298

[45] Daniel Callahan's proposal has attracted more detailed and sustained criticism than has Norman Daniels' approach. Cf. P. Homer and M. Holstein, eds. *A Good Old Age: The Paradox of "Setting Limits"*, (New York: Simon and Schuster, 1990); R. L. Barry and G. V. Bradley, eds., *Set No Limits. A Rebuttal to Daniel Callahan's Proposal to Limit Health Care for the Elderly*, (Urbana/Chicago: University of Illinois Press, 1991)

[46] Kathleen Dixon portrays Callahan as seeking to establish a new social order which necessitates a set of "founding myths", one of which is the "concept of a whole life". It is based on a perception of biological or natural, not cultural, realms and requires a recognition that (1) life has relatively fixed stages; (2) death represents an absolute limit; (3) old age is necessarily an experience of decline requiring a unique set of meanings; (4) our society would be better off if it shared a common view of the whole of life. K. M. Dixon, "Oppressive Limits: Callahan's Foundation Myth", *The Journal of Medicine and Philosophy* 19 (1994): 617-619

[47] Callahan, *Setting Limits*, 116

active way".[48] The age-criterion is important for rationing health care on the basis as to whether the natural life span has been completed or not.[49]

Not only does Callahan's approach rest on a controversial view about the value of life when the natual life-span is completed, it also depends on an even more dubious claim that human life has a *natural* span. The difficulty with Callahan's approach is the idea that there is some identifiable end point at which, for public policy purposes, some health care resources should no longer be funded. At one point in the discussion Callahan suggested that a lifespan of 75 years was as good as any. In *Setting Limits* he was slightly more conservative, identifying an age range of the late 70s to early 80s. The categorical nature of the cut-off point which seems demanded by his approach raises real difficulties. That a person at 74 might receive all possible medical care when another person of 76 would not creates difficulties for many commentators.[50]

A second difficulty with Callahan's *lifespan completion theory*, according to Robert Veatch, is to be found in his demand that the elderly have a continuing need for relief of suffering and basic nursing care. What the approach fails to explain is why resources should be spent on these when others will never reach their full life-span. If their "full" lives are over, why do they have claims for palliative and nursing care? May it not be argued that people who have not reached their full life span have claims for these same resources as well. Since basic nursing care for the elderly is a major resource investment, is it not more reasonable to dispose painlessly of those whose life-span is over so that attention can be given to those who have not yet attained the full life span.[51] Veatch is correct, I believe, when he claims that:

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[48] Callahan, *Setting Limits*, 43

[49] Winslow argued for exceptions to Callahan's categorical age-criterion for health care delivery. The significant particulars of individual cases must be part of moral reasoning. For Aristotle this is part of practical wisdom (*phronesis*). Callahan's inflexible application of categorical exclusions based strictly on age contradicts this requirement of moral reasoning. G. R. Winslow, "Exceptions and the Elderly" in *Facing Limits. Ethics and Health Care for the Elderly*, edited by G. R. Winslow and J. W. Walters, (Boulder, Co.: Westview Press, 1993), 236-37

[50] A parallel argument envisages the age-criterion as discriminating against the poor, the ignorant and the disadvantaged who would bear the brunt of any resource limitations. N. G. Levinsky, "Age as a Criterion for Rationing Health Care", *The New England Journal of Medicine* 322:25 (1990): 1814

[51] This argument is developed by Margaret Battin in "Age Rationing and the Just Distribution of Health Care: Is There a Duty to Die?" in *Should Medical Care Be Rationed by Age?*, edited by T. M. Smeeding, M. P. Battin, L. P. Francis, and B. M. Landesman, (Totowa, N.J.: Rowman & Littlefield, 1987), 69-94. She proposes that "direct termination of lives of the elderly more nearly achieves justice than denying them treatment..."(*ibid.*, 91)

> Callahan's instincts are stronger than his theory. It is intuitively obvious that we should continue to provide comfort care. I do not think Callahan's theory can explain why.[52]

A further difficulty with Callahan's age limit has been developed in terms of the *fair innings* argument.[53] Put simply arguments that support the setting of a threshold at an age which might plausibly be considered to be a reasonable lifespan support equally the setting of a threshold at any age at all, so long as an argument from fairness can be used to support this.[54]

In light of these criticisms it is obvious that Callahan's proposal for an age criterion appears seriously flawed. It would appear to me that his primary intent was to challenge his society to confront the reality of limits. Laudable as this aim is, it is not able to be effectively articulated as a coherent and sustainable public policy criterion. Two clarifications, however, must be made at this point. First, a number of critics of the age criterion proposal have frequently overlooked a distinction that must be made between Callahan's primarily philosophical agenda, urging a moral realism in American life and health care, and his policy proposal for an age criterion for health care delivery.[55] Second, Callahan's age criterion proposal applies to publicly funded, life-extending high-tech health care for people who have fulfilled their life span. He does not exclude the use of private funds for this purpose. This specification has frequently been overlooked by critics. These same critics have separated the public policy proposal from his more fundamental concern about the American ethos.[56] As a

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52 R. M. Veatch, "How Age Should Matter: Justice as the Basis of Limiting Care for the Elderly" in *Facing Limits. Ethics and Health Care for the Elderly*, edited by G. R. Winslow and J. W. Walters, (Boulder, Co.: Westview Press, 1993), 221

53 "The fair innings argument requires that everyone be given an equal chance to have a fair innings, to reach an appropriate threshold but, having reached it, they have received their entitlement. The rest of their life is the sort of bonus which may be cancelled when this is necessary to help others reach the threshold." J. Harris, *The Value of Life*, (London: Routledge & Kegan Paul, 1985), 91

54 Harris, *The Value of Life*, 92. "What the fair innings argument needs to do is to capture and express in a workable form the truth that while it is always a *misfortune* to die when one wants to go on living, it is not a *tragedy* to die in old age; but it is on the other hand, both a tragedy and a misfortune to be cut off prematurely."(*ibid.*, 93)

55 Many of Callahan's liberal critics have misrepresented his thought by failing to appreciate this fact. McCoy and Schonsheck have, in my opinion, offered the most accurate exposition of his general framework. Cf. J. A. McCoy and J. Schonsheck, "Concerns About 'Setting Limits: Medical Goals in An Aging Society': Review and Replies to Critics", *BioLaw* 2:44 (1990): S.491-S.508

56 Cf. Among a large body of such critics see N. S. Jecker, "Disenfranchising the Elderly from Life-Extending Medical Care", *Public Affairs Quarterly* 2:3 (1988): 51-58; N. S. Jecker, "Towards a Theory of Age-Group Justice", *The Journal of Medicine and Philosophy* 14 (1989): 655-76; N. S. Jecker, "Appeals to Nature in Theories of Age-Group Justice", *Perspectives in Biology and Medicine* 33:4 (1990): 517-27; N. K. Bell, "What Setting Limits May Mean. A Feminist Critique of Daniel Callahan's 'Setting Limits'", *Hypatia* 4:2 (1989): 169-78; J. W. Walters, "Ethics and Aging: Callahan and Beyond" in *Facing Limits. Ethics and Health Care for the Elderly*, edited by G. R. Winslow and J. W. Walters, (Boulder, Co.: Westview Press, 1993),

stand alone policy criterion the age standard is defective and untenable for the reasons elaborated above. As a catalyst for public discussion about the central values for American society it has been quite successful. Callahan's journalistic style, philosophical preoccupation and prolific published output has not endeared him to critics who take a much narrower perspective.

5.1.4.2 Daniels' Account

Daniels meets the criticism head on that setting age limits seems as unfair as allocation of resources based on race or gender. He argues that age is different. It is necessary to adopt what Daniels calls an *intra*personal rather than an *inter*personal perspective in dealing with age as an allocation criterion.[57] The policy task is to allocate personal shares of health care over a lifetime rather than allocating care interpersonally among cohorts of different ages. Whatever one's personal share, it seems to make no moral difference how it is allocated over one's lifetime. It is not necessary to have the same kinds of medical services available at different points in our lives. Allocation ought be based on what he calls an *age-specific normal opportunity range*. Appropriate distribution of goods provide what people need to function well at a particular age: to play sports in one's youth, to reproduce in early adulthood, to pursue a vocation in middle age, and to pursue active retirement in old age. It is a matter of prudence how an individual allocates his or her share of health care. For this reason Daniels refers to his scheme as a *prudential life-span account*. Each person is free to structure health insurance in any prudent way that is judged appropriate to him or her.

Not all allocation decisions, however, are ethical. That they be ethical requires that corrections be made for particular problems arising from the choices people make about their insurance. Choices must be adequately informed, empathetic, willing to

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293-308. Some take the further step of accusing Callahan of presenting a totalitarian argument for "it suggests that individuals have a place in a broader social structure and that their lives are to be dedicated to the achievement of that broader objective." J. F. Blumstein, "Age-Based Rationing of Medical Care: A Legal and Policy Critique", *St.Louis University Law Journal* 33:3 (1989): 698-699. See also R. L. Barry, "Mandatory, Universal Age-Based Rationing of Scarce Medical Resources" in *Set No Limits. A Rebuttal to Daniel Callahan's Proposal to Limit Health Care for the Elderly*, edited by R. L. Barry and G. V. Bradley, (Urbana: University of Illinois Press, 1991), 3-14

[57] D. McKerlie, "Equality Between Age-Groups." *Philosophy and Public Affairs* 21:3 (1992): 275-95 observes that "the prudential lifespan account is uneasily suspended between complete lives egalitarianism and a view that makes full-strength claims about equality between people of different ages."(*ibid.,* 288) He claims that it is hard to understand "why the prudential lifespan account should be interpreted as a substantive and independent principle of justice. On the other hand, if there are interpersonal claims of justice applying to distribution between age-groups, Daniels' theory fails to explain the source of the claims."(*ibid.,* 285)

take other people's life plans into account and so forth. Hence the need for a veil of ignorance - after the fashion of John Rawls' theory of justice - before those making a prudent allocation of health resources. Under these conditions deliberators would save a prudent amount for old age.

It is problematic whether Daniels' account makes clear that people choosing their health care allocation behind a veil of ignorance will choose an allocation that is prudent.[58] Likewise it is not obvious that it is only a matter of prudence as to how resources are allocated to different stages of the life cycle. Even if it is prudent for people to save for their old age, it may not be just or fair. The Rawls-Daniels scheme is based on a model in which rational, self-interested heads of households (blinded as to their specific interests and needs) are viewed as the ones making the allocation choices. This model, however, implies that all will inevitably reach adulthood. However, the natural lottery treats some more harshly than others. They are born with congenital and genetic problems such that they will suffer from critical, fatal, or permanently handicapping conditions. If a majority of rational adults spend equally on conditions of infancy, middle age, and old age, it does not follow that it is fair to those who will never reach adulthood.

Robert Veatch has argued that the real issue is whether justice permits or requires limits on care for the elderly.[59] Choices ought to be constrained by what is fair rather than simply by what seems prudent.[60] The principle of fairness obliges us to deal with the just claims of those who have critical or fatal conditions in infancy. Justice requires identifying the worst-off individuals and allocating resources so as to give

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58 Brock wonders whether Daniels' prudential lifespan approach differs from the conventional appeal to needs. Brock, "Justice...," *Philosophy and Public Affairs*, 301. Daniels' theory places too much moral weight on opportunity for "health-care is important also for its effects in relieving or preventing pain and suffering and improving the quality of life in respects independent of opportunity."(*ibid.,* 305) Brock makes the telling comment that even when there is scarcity of resources that it is not clear that "prudent planners with a lifetime fair share of health-care resources would exclude coverage of substantial amounts of life-extending health care beyond the normal life span." Brock, "Health-Care Entitlements...," in *A Good Old Age?*, 150-151

59 Veatch, "How Age Should Matter...," in *Facing Limits*, 222. Veatch rejects the prevailing utilitarian rationale for age-based rationing which emphasises maximising the common or aggregate good. Critics reject age as a criterion for maximising the aggregate good. First, they point out that some elderly can be very productive citizens. Second, they indicate the disutility entailed in the psychological burden of anticipating an old age without life-sustaining medical care. Third, the psychological and economic burdens on families whose elderly members are excluded from health care that could offer at least marginal benefits is not acknowledged.(*ibid.*, 216)

60 Veatch acknowledges that this commits him to a different version of the hypothetical contract to that of Rawls and Daniels. "I view contractors as discovering a preexisting moral structure, not simply choosing what is prudent." Veatch, "How Age Should Matter...," in *Facing Limits*, 229, note 16

those persons an opportunity to be as well off as others. The consequence for Veatch is that certain kinds of health care give priority to the young.[61]

Daniels' ideal theory of justice with its view of the prudent self-directing individual making allocation decisions for himself or herself over a life-time is open to a number of basic criticisms.[62] It is not easy to see, in the world of every day allocation decisions, how Daniel's incorporates the competing choices of others in the community. Furthermore, the thin set of values relating to personal autonomy offers no guidelines for discerning whether an individual has chosen correctly or has grasped more than is right. Veatch is correct, I believe, in highlighting the justice dimensions of prudent decision-making. For Daniels, however, the fundamental atomist/liberal view underpinning his thinking makes it almost impossible for him to sustain the validity of the age criterion when communitarian concerns are raised.

The liberal and communitarian approaches of Daniels and Callahan must be judged, in light of the above considerations, to have failed. They do not consider adequately the issue of limits. Their argumentation offers a partial and inadequate justification for the implementation of an age criterion governing health care delivery for the elderly. For this reason it may be concluded that the age criterion proposal has failed.

5.2 INTERGENERATIONAL OBLIGATIONS AND HEALTH CARE

5.2.1 Daniels and Obligations Between the Generations

In secular democratic societies there is a diversity of beliefs about family obligations. For this reason they provide a poor foundation for public policy.[63] Liberal thinkers

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[61] Veatch, "How Age Should Matter...," in *Facing Limits*, 223

[62] Churchill judges Daniels' theoretical framework a failure since it is "not concrete, particularized, or historically nuanced enough to remedy what he calls our 'obsession with competition for resources'." L. R. Churchill, "Private Virtues, Public Detriment: Allocating Scarce Medical Resources to the Elderly", *Ethics* 100 (1989-1990): 173. Daniels acknowledges that "the equal opportunity account does not tell us just how to limits services under resource constraints...The incompleteness ascribed to the equal opportunity account, and to liberalism more generally, derives from a general incompleteness of distributive theories that do not incorporate a theory of rationing...Communitarians in general can no more solve the problem of rationing by direct appeal to their values than adherents to liberal principles." N. Daniels, "Liberalism and Medical Ethics." *Responsive Community* 3:3 (1993): 46

[63] Brock has observed that both Daniels and Callahan "argue that no general moral argument succeeds in showing that children are obligated to provide the care their parents need. Moreover, there is no consensus among actual families on the care and aid that children owe their elderly

such as Daniels object to legal sanctions being used to enforce such familial obligations. The task for the liberal thinker is to clarify the parameters of social obligation and then design institutions that ensure justice between age groups. Such frameworks should permit people to pursue their family responsibilities as their moral convictions dictate.

In exploring the limits of family obligations Daniels outlines the nature and extent of such obligations. He rejects a traditionalist understanding of family together with filial obligations based on the Judaeo-Christian reading of the commandment, "honour your father and your mother"[64]:

> What the Traditionalist nostalgically sees as a warm network of love and family responsibility appears to the colder historical eye as a complex mechanism in which care was exchanged for access to the means of production (albeit, no doubt at least some of the time with a sense of love or moral obligation). Variations in the mechanism often reflected difference in the kinds of property transmitted and the types of control over future livelihood the parent could exercise.[65]

Daniels considered five philosophical accounts of filial obligations.[66] One view holds that family obligations arise as the corollary of parental duties to care for their children. A second approach argues that the parent who does his or her duty delivers a benefit to the child. The beneficiary acquires an obligation to reciprocate. A third argument, developed by Jane English and widely referred to in the literature, proposes that what adult children should do for their parents grows from the bonds of friendship they develop with their parents. Another explanation views filial obligations as a special case of the (imperfect) duty of beneficence. A fifth approach is proposed by Daniels himself. He maintains that certain socially important, traditional relationships which provide fundamental goods to individuals such as those occurring within families may give rise to special duties. In light of these accounts Daniels has concluded:

> [there are no] compelling foundations for filial obligations, even though it may strike us as rational and fitting and praiseworthy that (most) children want to help their parents . . . Without agreement on these limits, filial obligations cannot be made the basis for laws enforcing family responsibility.[67]

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parents which might instead guide public policy." Brock, "Justice...," *Philosophy and Public Affairs*, 298-299

64 Ex.20:12

65 Daniels, *Am I My Parents' Keeper?*, 27

66 Daniels, *Am I My Parents' Keeper?*, 28-34

67 Daniels, *Am I My Parents' Keeper?*, 34

Nevertheless, Daniels is convinced that familial obligations must be both just and social. His pedigree as a liberal is much in evidence as he explores the connection between justice and familial obligations. Principles of justice provide the framework of institutions where people with differing views as to what is right and good can cooperate as a social unit. Modern societies are constituted by people with different goals and life projects, varied beliefs and fundamental moral stances. An appreciation as to what individuals owe their parents is to be found among these beliefs. Daniels argues that:

> [I]t is the task of a theory of justice to provide us with principles that can act as a final and publicly acceptable basis for resolving disputes about how basic social goods, such as liberties, opportunity, income and wealth should be distributed among people who disagree about many other things. Justice must provide a framework for cooperation among individuals who may nevertheless disagree about much of what is good in life and about many of the ways they treat each other as individuals.[68]

In pursuing a liberal understanding of justice Daniels does not privatise obligations to parents. His focus on the role of justice ensures that these obligations have a social dimension. For that reason he strongly resists the libertarian position of thinkers such as Nozick who hold that "(n)o social obligations exist . . . except to defend the society against external interference and to protect individuals from violations of their rights to property and security."[69] Daniels' approach appeals to filial and other individual obligations in a way that enhances family responsibility. It comes close to the traditionalist view but for quite different reasons.

Daniels builds on his justice perspective of filial obligations when he investigates the link between filial obligations and the duty of the wider society to support the aged. Because families basically cooperate with society both groups mutually benefit. This is particularly the case when families function normally. "Where a cooperative arrangement produces mutual benefits in the normal case, *legitimate expectations* arise about the importance of reciprocity and the importance of sustaining the kinds of interpersonal relationships which generate these benefits."[70] Filial obligations, therefore, are the norm. But there is a proviso. The obligation to aid another family member must not, according to Daniels, be open ended. The obligation to aid family members may well require more than obligations to aid one's fellow citizens, but

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[68] Daniels, *Am I My Parents' Keeper?*, 35-36

[69] Daniels, *Am I My Parents' Keeper?*, 38

[70] Daniels, *Am I My Parents' Keeper?*, 112

there is nothing in the way it is grounded that obliges children to seriously threaten their well-being (or their children's) in aiding parents.[71]

How then, according to the *prudential lifespan account*, do limited filial obligations mesh with the obligation of society to provide long-term care? Daniels offers two considerations. First, social obligations have a certain primacy:

> The needs for long-term care must be met even if individuals neglect their family obligations. Moreover, limited filial obligations cannot be expected to meet extensive and burdensome needs for long-term care. Social obligations to meet these needs have to be satisfied.[72]

Second, different societies with different family institutions may inculcate more or less extensive family responsibilities. Such societies may then want to divide the responsility for long-term care differently, yet each could be just. Justice thus respects various cultural differences. Aging in first world countries has altered human living so much so that it is no longer possible to look at the problems of the old as exceptional ones. Rather, society must now adjust its institutions and policies to accommodate the new shape of human existence arising from increased longevity.[73]

5.2.2 Callahan on Intergenerational Obligations

In his analysis of the moral foundations of obligations to the elderly Callahan's first concern was to understand the moral foundations of Medicare as it exists in the U.S.A.[74] While doing this he questioned whether it is possible to respect the dignity of the aged, to fully acknowledge their contributions and accomplishments, and yet at the same time contemplate a limit to some forms of health care?[75]

Currently in health care there are strong economic pressures to finds ways to have children provide care for aged parents. These pressures display a mix of financial, ideological and charitable motives. If children are to shoulder this burden three basic questions must be answered: (1) What kind of moral obligation do children have toward the welfare of their elderly parents? (2) What are the limits of this obligation?

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[71] Daniels, *Am I My Parents' Keeper?*, 114

[72] Daniels, *Am I My Parents' Keeper?*, 114

[73] Daniels, *Am I My Parents' Keeper?*, 115-116

[74] Bayer and Callahan. "Medicare Reform...," *Journal of Health Politics, Policy and Law*, 535-537.

[75] Callahan, *Setting Limits*, 82

(3) Even if children do have some significant duties to parents, is it still legitimate to ask the state to take over much of the direct financial burden of care?[76]

Reference has already been made to the changed social environment in which the elderly now find themselves. Two myths must be debunked. The first is that the caring family has disappeared among all the changes. The second is that the elderly are now more isolated from their children than ever before. All the evidence points to the fact that children and families remain the principal source of emotional support and companionship for the elderly.[77] Within society it is generallly accepted that respect and care are owed to the elderly. Giving a coherent and satisfactory explanation for this phenomenon is more difficult. This is the challenge Callahan takes up.

His philosophical reflection commences with the *piety* of classical Greek and Roman societies. The aged in the ancient world were seen to pass on the values and traditions of the culture. They were viewed as having a wisdom that was gained from living and suffering throughout a long and reflective life. The principle of reciprocity would seem to underpin the classical view of old age. The young owe a debt to the old, just as one day their children will owe a debt to them. The generations are thus understood to be inextricably linked to each other. Respect for the elderly is a central element in this intergenerational bond.[78]

Christianity shaped its understanding of the parent-child bond in the context of the commandment, "honour your father and your mother". This apodictic teaching must be appreciated within the casuistry of the Jewish tradition. In the ancient world familial obligations were lived out in agrarian and urban environments. With the advent of industrialisation significant changes occurred in family existence. One facet of these changes is to be found in the way governments have increasingly involved themselves in family life. A gradual lessening of the coercive power of parents over their children paralleled this development.

Callahan located the beginning of legal involvement in filial obligations with the Elizabethan Poor Law of 1601. This legislation attempted to deal with the problem of the poor in English society. Its purpose was to make the family, as a unit, responsible for poverty-stricken relatives. During the seventeenth and eighteenth centuries it passed into the legislation of the American colonies with particular emphasis being

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76 Callahan, *Setting Limits*, 84-85; Callahan, "What Do Children…," *The Hastings Center Report*, 32.

77 Callahan, *Setting Limits*, 86

78 Callahan, *Setting Limits*, 86-87

given to the responsibilities of children toward elderly parents. Callahan notes that the primary purpose of such laws was to protect the public from the burden of caring for the poor, including the elderly. Three moral assumptions underpinned this type of legislation. First, a notion of reciprocity demanded that a child support his or her parents. This was a mirror image of the parents' responsibility to support a child. A second assumption views family relationships as creating a special tie between parent and child which requires children to support elderly parents. A third or moral premise arises from the fact that the child was at one time supported by his or her parent. This creates an implicit contract requiring the child, in turn, to support the parent when necessary.[79]

Here it is important to note the way Callahan explains familial intimacy and moral language. The parent-child relationship is:

> a relationship that appears almost but not quite self-evident in its reciprocal moral claims and yet oddly elusive also. We seem to say too much if we try to reduce the relationship to mutual moral duties, rights and obligations. That implies a rigor and formalism which distorts the moral bond. We say too little if we try to make it a matter of voluntary affection only. Yet we cannot, I suspect, totally dismiss the language of obligation nor would we want to give up the ideal of mutual affection either . . . There need not be, then, any necessary incompatibility between feeling both affection and a sense of duty. But we lack a moral phrase that catches both notions in one concept; and neither taken separately is quite right.[80]

Callahan isolates three dimensions of the parent-child relationship. First is the role played by friendship and gratitude in the unique child-parent relationship. Jane English has argued that the duties of grown children should be that of friends to their parents.[81] Love is the basis of this friendship. In place of reciprocity she emphasised mutuality. The *ought* that arises in child-parent relationships is one of friendship. Callahan finds English's approach ultimately unsatifying. Many adult children do not see their parents as friends but nonetheless feel respect and love for them. Gratitude has been proposed as another basis for the unique parent-child relationship. It, too, has difficulties similar to the friendship model. Callahan has noted that gratitude is ordinarily judged to be due when a benefactor has gone beyond the requirements of

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[79] Callahan, *Setting Limits*, 88-89

[80] Callahan, *Setting Limits*, 93; Callahan, "What Do Children…," *The Hastings Center Report*, 35

[81] Cf. J. English, "What Do Grown Children Owe Their Parents?" in *Having Children: Philosophical and Legal Reflections on Parenthood*, edited by O. O'Neill and W. Ruddick, (New York: Oxford University Press, 1979), 351-56

ordinary duty. In some cases, parents may have done their duty, but in such a grudging way that no gratitude seems due them.[82]

A second aspect arises from the dependence of the elderly on their families. Callahan has asked whether dependence alone creates the obligation to care. He turns to the practical and specific demands that parents make on their children. In thinking this through he offers an answer in two parts. On a scale of moral priorities it would be difficult to argue persuasively that persons in a middle generation have an obligation to deprive their dependent children of necessary financial support in order to support their elderly parents. Children have a claim on their parents which a parent's parents cannot equal. In ordinary terms, then, the primary economic duties of adults are to their own children rather than to their parents.[83]

Physical help and affection, however, are another matter. In distinguishing these two aspects Callahan has argued that an inability to provide a particular kind of care does not exempt children from providing other forms of care. At times physical help is difficult to give. However, elderly parents very often require affection and the emotional and psychological support that goes with it. It should be noted here that Callahan nowhere develops an argument explaining the origins of filial obligations. He seems satisfied with sketching commonly held perceptions within his community.

The third dimension of the parent-child relationship is developed by Callahan when he discussed chronic illness and the need to set limits to family obligations. Chronic illness seriously challenges common understandings of child-parent duties. The burdens of chronic illness impose enormous pressures on family functioning. This, in turn, confronts traditional moral expectations about family life.[84] The current trend in health care delivery is to locate care of the chronically ill and the frail elderly in the domestic setting. The momentum in favour of this policy assumes that families, with some modest degree of social support, will be able to manage such care. Furthermore, it is assumed that family members have the moral, psychological, and spiritual strength to sustain such care. Callahan has questioned these assumptions, particularly when a frail, sick, or demented parent requires many months or years of demanding, stressful care.[85]

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82 Callahan, *Setting Limits*, 91

83 Callahan, *Setting Limits*, 94

84 Jennings, Callahan and Caplan, "Ethical Challenges of Chronic Illness", *The Hastings Center Report*, S12

85 Callahan, *Setting Limits*, 96

Callahan acknowledges that children have a duty to give time and affection, and physical help when possible, to their elderly parents. The limits to such support, and the proper context for claiming it, are less clear. As a way into the problem he focuses on the situation where the welfare and happiness of the person who acts as carer is threatened. Frequently the burden of care falls on the daughter in the family. Callahan observes:

> Vulnerability most requires a response from someone who deeply cares, someone who will remain faithful - but faithful to us as a special and distinctive person, not as a mere object of moral duty or universal love . . . All of this is simply to say that at the heart of any significant moral obligation is the vulnerability and ultimate neediness of another and, in the context of family life and illness, a vulnerability that often can fully be responded to only by a family member.[86]

Does this demand unlimited self-sacrifice by the caregiver? Callahan is uncomfortable with a *yes* answer. He has preferred to chart the morally reasonable demands of self-love and self-interest as a way through to understanding the limits of familial obligations. To this end he finds Stephen Post's study of the duties of parents to impaired newborn children of some help. Callahan sees this parallelling an adult child's duty to care for an elderly parent. Post has attempted to circumscribe radical forms of self-denial entered into for the good of others. According to Post attention must be paid to (1) the interests and needs of third parties such as other children and family members; (2) the avoidance of melancholy and introspective self-obsession where self-denial suits the purpose of the agent rather than the loved one; (3) a limitation for the sake of the child himself or herself, who could be said not to want to impose undue burden or detriment; (4) a rejection of selflessness which depends upon the other for the carer's own sense of identity.[87] Even when armed with clarifications such as these Callahan has recognised that, in practice, it is almost impossible to describe in an adequate fashion the capacity of individuals to undertake the heavy burdens of caring for a family member.[88]

Because of this Callahan has directed his attention to the kind of moral resources required for family members to carry out demanding care. He has delineated features of care that impose the sharpest moral demands on the caregiver. He writes of "those features that seem to pose a direct and fundamental threat to the welfare and happiness of the person who gives the care, where the caregiver may become - by the

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86 Callahan, *Setting Limits*, 101

87 Callahan, *Setting Limits*, 103-104

88 "We cannot, therefore, readily establish any set of reasonable expectations of caregivers when heroic, extraordinary caregiving is needed. By definition, extraordinary needs require extraordinary moral resources, and not all, or even most, people have them." Callahan, *Setting Limits*, 104-105

sacrifice demanded and extracted - as much a victim of the illness or disability as the person who is cared for."[89]

Callahan has explored the range of experiences present in the lives of adult caregivers. Caring for an elderly parent in the home often generates feelings of anger. This not infrequently leads to guilt. Fantasies about the death of an elderly parent add to the spiral of guilt. Even the caregiver's own sense of self-worth is jeopardised at times. Uncertainty about the future, especially when rehabilitation is involved, induces a sense of hopelessness in the caregiver.

The philosophical dilemma arising from the need to care for elderly parents is directly linked to the fundamental question as to how commitments to family members can be justified. These demands do not neatly fit contractual frameworks. Contemporary thinking requires a moral act to arise from a free, autonomous choice. Noncontractual moral obligations thus become highly problematic. They violate human autonomy falling as they do into the realm of supererogation. This is commendable, virtuous and edifying if freely chosen, but is not required in the name of morality. The philosophical intent in drawing this sharp demarcation line in human activity is not primarily selfish. Rather it stems in great part from the inability of philosophers to establish a solid moral basis for involuntary self-sacrificial behaviour that springs from contextual, not contractual demands.[90] A deeper problem is that self-sacrificial morality

> cannot be sustained by will alone. A presumption of much secular, individualistic morality is that one ought to do one's duty, and that good reasons for moral behavior are sufficient motivation. One need only make up one's mind to act in a certain way, will to so act, and the actions will follow. But there are too many good-willed but still angry caregivers around to sustain that view. It is psychologically naive. It takes account neither of our emotions (which color our judgment and will from the inside) nor of the social setting of our actions (which influence our judgment and emotions from the outside).[91]

Callahan's point is well made. He has concluded that heroic self-sacrifice is only possible if understood within the context of an entire way of life, and a way of life set ultimately within some scheme of religious or higher meaning.[92] The care of another must be transformed from a stark and unpalatable moral demand, he has argued, into

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89 D. Callahan, "Families as Caregivers: The Limits of Morality", *The Archives of Physical and Medical Rehabilitation* 69 (1988): 324

90 Callahan, "Families as Caregivers...," *The Archives of Physical and Medical Rehabilitation*, 326

91 Callahan, "Families as Caregivers...," *The Archives of Physical and Medical Rehabilitation*, 326-327

92 Callahan, "Families as Caregivers...," *The Archives of Physical and Medical Rehabilitation*, 327

a satisfying moral vocation, one honoured by the community and returned in kind when the caregiver himself or herself comes to need care[93]:

> Vulnerability is understood to be part of the human condition, some being visited with greater needs than others, but others being blessed with greater strength. A distinction is still made between duty and moral heroism, but the level of duty is set much higher, there is less nervousness about the boundary line, and heroism is thought to be required of all lives from time to time. A good society is one that finds ways to match needs and strengths, one that cares not only for public injustice visited on minority and other weak groups but also for private injustices that nature and life visit upon individual people.[94]

These reflections have provoked Callahan to explore the social and moral foundations of American public policy toward the elderly. He was unable to find a central or unifying idea. The elderly have been granted neither a natural nor a constitutional right to assistance. Social security programs have not been developed with a clear sense of the mutual responsibility or solidarity between generations. Rather, the right of the elderly to government aid has usually been understood as part of an earned right. Closely related is the notion of *veteranship* which emphasises the contributions and sacrifices made by the elderly throughout their productive lives. Furthermore, more recent Medicare programs appear to be based on appeals to need and the vulnerabilities of old age. American social policy toward the elderly expresses mixed motives: (1) the self-interest of the young as they look toward their old age; (2) the desire of the young to be spared the full weight of caring for elderly parents; (3) the aim of prudent government to avoid being saddled with an even worse economic burden if some early relief is not afforded the old; (4) moral motives of respect and affection for the elderly; and (5) a sense that a decent community should protect its weak, its frail, and its vulnerable from the ravages of old age.[95]

Callahan believes that the great increase in life expectancy generally in society provides a solid reason for arguing that everyone, through the state, should supply the elderly with basic economic and medical support. A minimal government duty should be to do nothing to hinder, and when possible what it can to protect, those ties which give familes their power to nurture and sustain their members.[96]

In concluding his analysis of intergenerational obligations Callahan puts forward fragments of a synthesis.[97] In view of the needs of the old Callahan contends that the

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93 Callahan, *Setting Limits*, 106

94 Callahan, "Families as Caregivers...," *The Archives of Physical and Medical Rehabilitation*, 327

95 Callahan, *Setting Limits*, 109

96 Callahan, *Setting Limits*, 110

97 Callahan, *Setting Limits*, 110-114

young have a duty to the elderly simply because the needs of the latter group are undeniable and only the young can respond to them. He believes it is not necessary to choose between *need*, *veteranship* and *reciprocity* as a moral and social foundation for care of the elderly. Need provides the strongest basis when a response is required to be made to elderly individuals. Veteranship and reciprocity ground our dealings with them as a group. It is not simplifying matters too much to say that need refers primarily to the present, veteranship to the past and reciprocity to the future.

When considering the needs of aged persons and the needs of the self (especially in the case of the caregiver) Callahan has conceded there must be limits to altruism and self-sacrifice. In practice it is more difficult to decide where the line is to be drawn. Often, family members are the ones best able to provide the care required by elderly relatives. Community groups and government support must be willing to alleviate the situation even if they cannot remove difficult and even tragic situations. Government has a fundamental duty to care for the elderly. On the other hand, it is families who have a critical role in providing a personal care that is beyond the scope of public bodies. This balance is a critical factor in Callahan's proposal to limit health care to the elderly. As he says:

> its purpose should *not* be to spare the young the care of the old. Its purpose must be to see that each age group gets what it truly needs to live a life appropriate to it, and to see that each age group gives to the others that which it alone can give.[98]

This plea for a recognition of human interdependence offers a fitting conclusion to Callahan's communitarian analysis of intergenerational obligations. It is now possible to make a critical assessment of the contributions of both Daniels and Callahan to the topic.

5.2.3 Evaluation of the Contribution of Daniels and Callahan

5.2.3.1 Myths, Families and Elderly Parents

Recent literature on the relations of adult children to aging parents has contributed to the myth that the elderly have become alienated from their families.[99] The reasons offered are varied. With increased mobility in society parents frequently live at great distances from their children, with the result that they see them rarely. Life in nuclear

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[98] Callahan, *Setting Limits*, 114

[99] E. Shanas, "Social Myth as Hypothesis: The Case of the Family Relations of Old People" in *Aging and the Human Spirit. A Reader in Religion and Gerontology*, edited by C. LeFevre and P. LeFevre, (Chicago: Exploration Press, 1981), 128-34. See also S. V. Brakman, "Adult Daughter Caregivers", *The Hastings Center Report* 24:5 (1994): 26

families has had the effect of elderly parents seeing their siblings and other relatives less often than in earlier times. Bureaucracies concerned with the needs of the elderly have lessened the role adult children have in caring for aging parents.[100] The myth that parents are alienated from their adult children has gained credence in contemporary society assisted by the perception that the family has ceased to be the basic economic unit of society. Sociological theories, such as the one proposed by Talcott Parsons, have also had considerable influence. Parsons has promoted the idea that the primary function of the nuclear family is to socialise the child. Often overlooked is Parsons' equally important insight that the family is an essential basis for security for adults in later life. More recently social data has indicated that the modified extended family provides the context, at least in developed countries, within which most people grow into old age. In fact, family members provide the greater part of care for the aged.

Daniel Callahan, in his effort to give value to human aging, comes dangerously close to generating another myth. In his writings he suggests it is the elderly who have a unique capacity to link past, present, and future. Because of this he views them as *moral conservators*. By serving the young and future generations the elderly gain not only a sense of meaning for themselves but also attain a greater social significance within the human community.[101] Callahan's understanding of old age is dangerous for it overlooks the role of gender in intergenerational care, particularly the significant role middle aged women play in caring for both aged parents and young children.[102] Furthermore, Callahan has not connected the social roles filled in earlier adult life with what he proposes for old age. The gendered nature of the roles preceding old age can be judged to make a great deal of difference as to how old age unfolds in human lives. Anticipating a particular role for old age likewise influences the roles of earlier life. Earlier stages in the life cycle are quite different for men and women. Women in their care of children are directed to care in ways men are not. For this reason it is fair to conclude that a "gendered description of the stages of life is

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100 Shanas, "Social Myth...," in *Aging and the Human Spirit*, 131

101 K.M. Dixon misrepresents Callahan's thought when she paints a bleak picture of the elderly and their role: [t]he aged are on a voyage of self-denial and ultimately extinguishment as they socialize and educate the youth, emptying themselves of knowledge and power. Resources exhausted, skills and insights transmitted, the aged divest and withdraw, shrinking towards death." Dixon, "Oppressive Limits...," *The Journal of Medicine and Philosophy*, 632

102 "The current average caregiver to the elderly is forty-five years old, female and married." Brakman, "Adult Daughter Caregivers", *The Hastings Center Report*, 26. Betty Friedan writes of the "superwoman squeeze", cf. S. G. Post, "What Children Owe Parents: Ethics in an Aging Society", *Thought* 64 (1989): 316. See also S. G. Post, "Women and Elderly Parents: Moral Controversy in an Aging Society", *Hypatia* 5:1 (1990): 84-85; Dixon, "Oppressive Limits...," *The Journal of Medicine and Philosophy*, 632-636

necessary to understand adequately the implications of Callahan's new role for the last stage of life."[103]

5.2.3.2 The Ethical Struggle with Intergenerational Obligations

Modern philosophical ethics has had little to say regarding family relationships and obligations.[104] This is somewhat anomalous since much of daily living is experienced within the context of family networks. It has been suggested that this hiatus in modern Anglo-American philosophy has ignored the social and biological contexts of human existence in favour of the Enlightenment view of the human self.[105] Atomist rational beings, virtually unconnected to others in any essential manner, have little or no need for a theory of filial morality. Whether Kantian or utilitarian, post-Enlightenment moral thought has adopted an impersonal standpoint which overlooks the tendency "to treat preferentially people to whom we are related by special ties of affection, such as parents, children, spouses, friends, and lovers."[106] The *moral point of view* has gone too far in the direction of impartiality. The result has been that *special relations* have been ignored, or at least overlooked. From the perspective of strict universal impartiality such relations are instances of merely irrational sympathies. Current moral philosophy that emphasises the social contract is primarily concerned with what we owe to one another as strangers rather than what we owe to friends or kin. Indeed, "all so called 'special-relations' such as husband-wife, father-daughter, brother-sister are seen as ethically anomalous."[107] The moral field is one in which all persons, no matter how distant, have absolutely equal claim on the moral agent. Morality thus becomes a matter of transcending the familial.[108]

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[103] B. Spielman, "Achieving Equity and Setting Limits: The Importance of Gender" in *Facing Limits. Ethics and Health Care for the Elderly*, edited by G. R. Winslow and J. W. Walters, (Boulder, Co.: Westview Press, 1993), 179

[104] S. G. Post, "Filial Morality in an Aging Society", *Journal of Religion and Aging* 5:4 (1989): 17

[105] "The self thus conceived, utterly distinct on the one hand from its own social embodiments and lacking on the other any rational history of its own, may seem to have a certain abstract and ghostly character." A. MacIntyre, *After Virtue. A Study in Moral Theory*, 2nd. ed., (Notre Dame, Ind.: University of Notre Dame Press, 1984), 31. For a critical analysis of the origins of modernity and the Enlightenment project see S. Toulmin, *Cosmopolis. The Hidden Agenda of Modernity*, (Chicago: University of Chicago Press, 1992)

[106] J. Blustein, *Parents and Children: The Ethics of the Family*, (New York: Oxford University Press, 1982), 174

[107] S. Hauerwas, *A Community of Character: Towards a Constructive Christian Social Ethic*, (Notre Dame: University of Notre Dame Press, 1981), 171

[108] Post, "Filial Morality...," *Journal of Religion and Aging*, 17-18. Post observes that for Gilligan it is women who "define themselves in a context of human relationship" and that by and large women judge their behaviour in reference to familial and other special relations involving considerable

The traditional moral foundation for obligations to the elderly has most often been developed in terms of intergenerational reciprocity. This term expresses the relatively simple notion that the old have duties toward the well-being of the young just as the young, in their turn, have duties toward the well-being of the old.[109] Gratitude is the attitude most often manifested in the reciprocal relationships within family. Blackstone in his *Commentaries* on English common law captured the implications of such reciprocity for filial morality:

> The duties of children to their parents arise from a principle of natural justice and retribution. For to those who gave us existence we naturally owe subjection and obedience during our minority, and honour and reverence ever after: they who protected the weakness of our infancy, are entitled to our protection in the infirmity of their age; they who by sustenance and education have enabled their offspring to prosper, ought in return to be supported by that offspring, in case they stand in need of assistance.[110]

Jeffrey Blustein has maintained the view that the duty of gratitude must be distinguished from that of indebtedness. While one may be obliged to be grateful even when what has been given was not voluntarily accepted, such is not the case when it comes to being indebted. Young children cannot exercise genuine choice with respect to being born, fed, clothed, nurtured and educated. Because they do not exercise real choice it follows that adult children should not feel they owe their parents anything at all. They are not indebted to their parents because they were not free when endowed as minors. Blustein goes further. He has argued that the office of parent is similar to that of a life-saver on the beach. Both are bound by virtue of the specific role undertaken. Because parents are merely discharging the duties of their office when they care for their children there exists no reciprocal duty on the part of children. "If parents have any right to repayment from their children, it can only be for that which was either above or beyond the call of parental duty, or not required by parental duty at all."[111]

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caretaking and nurturing. Feminist thinking is thus a counter to the Enlightenment requirement of impartiality (*ibid.*, 18).

[109] R. ter Meulen, E. Topinkova and D. Callahan. "What Do We Owe the Elderly? Allocating Social and Health Care Resources. Recommendations of a Joint International Research Group of the Institute for Bioethics, Maastricht, the Netherlands, and The Hastings Center, Briarcliff Manor, N.Y., U.S.A.", *The Hastings Center Report* 24:2 (1994): S7

[110] Sir William Blackstone, *Commentaries on the Laws of England*, Vol. 1, (New York: Garland Publishing, 1978), 453

[111] Blustein, *Parents and Children*, 182. See also S. Selig, T. Tomlinson and T. Hickey, "Ethical Dimensions of Intergenerational Reciprocity: Implications for Practice", *The Gerontologist* 31:5 (1991): 626

Jane English in a similar vein asked what grown children owe their parents. Her answer is that they owe them nothing. If, however, adult children and their parents have a friendly and loving relationship then the children might freely care for them.[112] Where friendship is non-existent filial obligations are suspended. English's rejection of reciprocity between parents and children assumes a contractual framework. In effect both Blustein and English have rejected an appeal to past parental sacrifices as the basis of an absolute filial obligation. They acknowledge only a relative obligation whose demands depend on both the extent and nature of the sacrifices made and the child's moral responsibility in accepting the parent's gifts.[113]

The justice framework underpinning the explanations of Blustein and English has been strongly resisted. Adopting the instrument of critical theory Nancy Jecker has radically revised the underlying assumptions of contractarian theory.[114] The problem with a justice framework is that it has been conceived in the tradition as a problem for breadwinners. Traditionally men have owned and distributed material property and wealth within both family and the state. In place of this Jecker has proposed a filial model for explaining obligations between generations. Emphasis is shifted from free choice and self-interest to filial affection. In so doing, it comes much closer to embodying the perspectives of mothers and children, who traditionally occupy a subordinate status within the family. The central problem of justice between generations is, therefore, not the transference of property from fathers to sons but a clarifying of responsibilities for those who care for the younger generation (mothers) and those who care for the older generation (adult children, particularly adult daughters). For Jecker:

> the duties between generations my account envisions are not freely chosen, instrumental rational, or self-serving. They arise instead from our natural sentiments and reflect our capacity to sacrifice our own interests to promote others' ends.[115]

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[112] English's approach is congruent with the notion of altruism discussed earlier in chapter 3.2.3. Beauchamp and Childress by the third edition of their popular *Principles of Biomedical Ethics* appear to have modified their understanding of the autonomous person in the context of liberal individualism (*ibid.*, 373) through their analysis of paternalism, beneficence and the obligation to rescue (*ibid.*, 200-203)

[113] Cf. S. Selig, T. Tomlinson and T. Hickey, "Ethical Dimensions of Intergenerational Reciprocity: Implications for Practice", *The Gerontologist*, 31:5 (1991), 627

[114] N. S. Jecker, "Justice and Mother Love: Toward A Critical Theory of Justice Between Young and Old" in *Voices and Visions of Aging*, edited by T. R. Cole, (New York: Springer, 1993), 275-88. Her analysis includes Hobbes, Locke, Filmer, Hume, Gauthier and Rawls (*ibid.*, 276-282)

[115] Jecker, "Justice and Mother Love...," in *Voices and Visions of Aging*, 284. Jecker also notes that her approach accords with recent feminist critiques of justice which (a) doubt the starting point of voluntary consent assumed in justice theories, (b) neglect the moral orientation of benevolence and personal relationships (Gilligan's ethic of care is an example), (c) challenge the notion of

Two issues must be borne in mind when assessing recent philosophical rationales of filial obligations.[116] First, it must be recognised that adult children generally fulfill their duties to their parents. Data on the informal care of the elderly in society is convincing on this point. Second, post-Enlightenment philosophical reflection has overlooked the significance and influence of the Judeo-Christian moral tradition. The commandment: "honour your father and your mother that your days may be long" has governed family life within the Jewish and Christian communities down through history. The Exodus commandment together with the directive that "each person shall revere his mother and his father" has been the basis of the Judeo-Christian understanding of the duties owed by children to their parents.[117]

5.3 SUMMARY AND CONCLUSIONS

5.3.1 Summary

Chapter 5 focuses on the two justice issues that preoccupy Daniels and Callahan in their studies of just health care for the elderly. The first is the public policy issue as to whether there ought to be an age criterion excluding certain categories of the elderly from receiving certain types of life-extending health care. The second, more philosophical issue arises from the difficulties that many middle aged children have in supporting and caring for elderly parents. The question here is: Are adult children obliged to care for aging parents? If the obligation exists, what is the nature and scope of this obligation?

In regard to the first issue Daniels and Callahan accept the public policy proposal of an age criterion in health care delivery. Daniels does so on the basis of his theory of justice, Callahan from the perspective of his understanding of the natural lifespan. In regard to the second question both authors recognise the difficulty in explaining the nature and scope of filial obligations. Anglo-American philosophy has given scant

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instrumental rationality underlying much social contract theory. The value neutrality assigned to rationality renders it too weak to carry the moral weight placed upon it (Gibson). Others (Lloyd, Jaggar) point out that no account of reason can provide a complete normative method or ideal.(*ibid.*, 285-286)

116 Cf. Selig, Tomlinson and Hickey, "Ethical Dimensions...," *The Gerontologist*, 625-626; Post, "What Children Owe Parents...," *Thought*, 320-324; S.V. Brakman, *A Philosophical Analysis of Filial Obligations*, Houston, Tx.: Rice University, 1993. Unpublished Ph.D thesis; S.V. Brakman, "Adult Daughter Caregivers", *The Hastings Center Report*, 28

117 Lv.19:3; cf. Post, "Filial Morality...," *Journal of Religion and Aging*, 24. The theological analysis in chapter 9 will consider the commandment.

attention to the nature of special relations such as those within the family. Two questions shaped the inquiry undertaken by Daniels and Callahan: How do we justify the obligation children have to care for aging parents? How do we describe the limits to such obligations?

5.3.2 Conclusions

I argue in chapter 5 that the liberal and communitarian approaches presented have been defective in responding to the issue of limits at both the philosophical and public policy levels. Daniels and Callahan offer only partial and inadequate justification for the implementation of an age criterion governing health care delivery for the elderly. For this reason the age criterion proposal may be judged to have failed. Furthermore, they do not justify or adequately describe the limits that might be placed on intergenerational relations. For this reason their philosophical analysis of such obligations must be considered to be inadequate.

PART III

ETHICAL RESPONSE: THE CONTRIBUTION OF ROMAN CATHOLIC MORAL THEORY

This study began with an outline of aged care policies in Australia (chapter 1). From this historical context the investigation developed in three stages. First, the basic problematic questions of the meaning of aging, health/illness and care were explored from a humanistic perspective (chapter 2). This understanding is central to any discussion of just health care delivery for elderly Australians. Second, a context was provided for a study of two proponents of just health care for the elderly. Since Daniels and Callahan have been leaders in the U.S. health care debate it was necessary to situate their contribution within the American scene. Chapter 3 considered the prevailing notions of justice and the liberal state, the underlying notions central to care of others, the goals and limits of health care and the particularities of U.S. health care delivery and ethical discussion arising from this. Norman Daniels' liberal approach and Daniel Callahan's communitarian thinking on justice, health care and the elderly followed from this (chapter 4). Third, the increasingly specific ethical analysis of chapter 3, leading as it did into chapter 4, came to a point in chapter 5 with the consideration of two limits situations in modern health care delivery, namely the age criterion proposal and the issue of intergenerational obligations. These have necessitated more detailed reflection on the justice dimensions of health care for the elderly.

The matters canvassed in Part II are now to be subjected to a theological analysis. The format of Part III mirrors the framework of Part II. In order to relate the specific contribution of Roman Catholic moral theory to the issues central to this thesis, chapter 6 provides a synthetic view of the tradition, preoccupations and agenda of the Roman Catholic Church and its theology. This prepares the way for chapter 7 which specifies the particular contribution Roman Catholic moral theory makes to the problematic issues regarding the meaning of aging, health and illness, and care. Chapter 8 develops three central ideas, namely the concept of the human person, the scope of the common good and the nature of justice as preferential-option-for-the-poor. These provide the content and rationale for the central argument of this thesis that Roman Catholic moral theory has something substantial to offer to the development of just health care for aged Australians. From within this richly textured understanding of human existence the issue of an age criterion for health care

delivery is evaluated. In chapter 9 the question of intergenerational obligations is pursued by studying the virtue of pietas as it is worked out in Christian responsibility for family members.

Part IV concludes this study with the argument that the theological reflection of the Catholic community contributes substantially to a more nuanced and satisfactory understanding of the issues involved in providing just health care for aged Australians. In light of this Chapter 10 offers a constructive proposal as to the way Roman Catholic moral theory might contribute to the development of just health care policies for the elderly in the Australian situation.

CHAPTER 6

THE RELEVANCE OF ROMAN CATHOLIC MORAL THEORY

6.1 The Moral Methodology of Catholic Moral Theology 269

- 6.1.1 Historical Perspectives 269
  - 6.1.1.1 The Bible and the Moral Life 269
  - 6.1.1.2 An Evolving Moral Exploration 274
  - 6.1.1.3 Vatican II to the Present 277
- 6.1.2 Theological Perspectives 280
  - 6.1.2.1 Faith and Morality 280
  - 6.1.2.2 The Theological Resources of Moral Theology ... 282
- 6.1.3 Normative Perspectives 290
  - 6.1.3.1 Value 292
  - 6.1.3.2 Obligation 295
  - 6.1.3.3 Virtue 298
  - 6.1.3.4 Vision 301
  - 6.1.3.5 Concluding Comments 303

6.2 Catholic Medical Ethics 304

- 6.2.1 Historical Background 304
- 6.2.2 Theological Dimensions 309
  - 6.2.2.1 Embodied Presence 309
  - 6.2.2.2 The Theological Dynamic: Faith, Hope and Charity 314
- 6.2.3 Normative Framework 318

6.3 Church and "Polis" 321

- 6.3.1 Religious Freedom 321
- 6.3.2 Pluralism 324
- 6.3.3 The Social Mission of the Church 328

6.4 Summary and Conclusions 332

- 6.4.1 Summary 332
- 6.4.2 Conclusions 332

CHAPTER 6

THE RELEVANCE OF ROMAN CATHOLIC MORAL THEORY

Chapter 6 argues that the Roman Catholic community and the moral theory it articulates present a coherent, traditional and dynamic approach to moral issues and health care dilemmas. Furthermore, the Church sees itself as a contributing participant within the social fabric, committed to working for the good of individuals and the whole community. It is argued in what follows that the Catholic tradition offers a richly textured set of answers to the fundamental human questions: "What sort of person ought I to be?" and "What sorts of actions ought I to perform?" Roman Catholic moral theory addresses these questions in ways which offer a potential contribution to the debate about an aging society. It is necessary, therefore, in this chapter to explain in some detail how the elements of Catholic moral theology have developed and where they stand at present, all with an eye to what they may contribute to better outcomes for an aging population.

Chapter 6 commences with a brief synthesis of the essential elements of Roman Catholic moral theory. Three lenses ground from historical, theological and normative perspectives are used to focus the presentation. Central to the structure of this chapter is the notion that Catholic Christianity is rooted in the historical experiences of the Old and New Testament covenant communities. A covenant theology is relational and is communitarian in a multitude of ways consistent with the recent revival of communitarianism in ethics. Furthermore, it shares the moral insights of all humanity based on personal consciousness of value and obligation but has a fuller and richer understanding of the moral life than is to be found in the ethical literature discussed thus far. Because of the vision of human existence coming from partnership with the God of the covenant, Christians think about human issues within a wider moral landscape. They are enabled to live the Christian moral imperative through virtuous lives assisted by God's Spirit. This capacity is not immediately available to human efforts alone. This is concretely illustrated in the medical ethic of the Roman Catholic tradition. It, too, is fundamentally theological, ecclesial and normative, all important elements bearing on analysis of issues relating to just health care for aged Australians.

In chapter 3.1 the central concepts of liberalism and liberal justice were outlined. Australian society may be judged to differ little from the liberal ethos prevailing in

America. One outcome of this has been that religious convictions are increasingly marginalised in contemporary Australia. It is necessary in this chapter, therefore, to demonstrate that Roman Catholic moral theory has an essential orientation to the public realm, to answer the question: "Does Roman Catholic moral theory have something to say of relevance to public affairs and to just health care for aged persons in particular?" The social mission of the Church is integral to the Church's self understanding. Commencing with the New Testament this self understanding is attested to throughout history. The pluralist dynamic of the liberal state, while posing challenges for the Catholic Church and its theology, has nevertheless enriched the Church's approach to the world and its understanding of its life and mission. For these reasons Roman Catholic moral theory resists any attempt to relegate its contribution to the backwater of sectarian teaching or the privacy of personal preference.[1]

Before entering into a detailed exposition in support of these arguments it is important to note here that the greater part of the literature canvassed in this chapter is American. This is so since very little published material has originated from within the Australian Roman Catholic Church.[2] The few moral theologians working in Australia have been engaged primarily in the pastoral activity of the Australian Church, as Church spokespersons or as advisors to Catholic health care.[3] Throughout its history the Australian Catholic Church has, at least in the theological arena, simply absorbed and adapted developments from overseas.[4]

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1. For an historical background to this see T. L. Suttor, *Hierarchy and Democracy in Australia. 1788-1870. The Formation of Australian Catholicism*, (Melbourne: Melbourne University Press, 1965), 3-4

2. *The Australasian Catholic Record* and *Pacifica* are the two main theological journals in the Australian Catholic Church.

3. Dr. Leslie Rumble M.S.C. was a leading spokesman during the sectarian debates of the 1930s to 1960s. His radio program "Question Box" was enormously successful. "Some 6000 of these questions, with Dr. Rumble's answers, were published in Australia and America in four volumes of *Radio Replies*. Between 1934 and 1954 these reached a circulation of seven million, to which must be added that of Dr. Rumble's fifty booklets on various religious matters." P. O'Farrell, *The Catholic Church and Community. An Australian History*, (Sydney: N.S.W. University Press, 1985), 373-374. Fr. Bill Daniel S.J. (d. 1995) has been the most widely published moral theologian working in Australia. Fr. Norman Ford SDB has written in the field of bioethics: *When Did I Begin? Conception of the human individual in history, philosophy and science*, (Cambridge: Cambridge University Press, 1988). Fr. Arnold Hogan S.J. published *Being Catholic Today. What kind of person should I be?* shortly before his death in 1996. The Redemptorist moralists, Frs. B. Johnstone and T. Kennedy, have published while living and teaching in the U.S. and Rome.

4. Until recently Australian scholars pursued postgraduate study in theology either in Europe or the U.S. With the establishing of the Australian Catholic University in the eastern states and Notre Dame University in the Western Australia home-grown tertiary level theology is now in its

6.1 THE MORAL METHODOLOGY OF CATHOLIC MORAL THEOLOGY

6.1.1 Historical Perspectives

A brief historical outline of the development of Catholic moral theology, drawn from a rich and varied theological tradition, enables an assessment to be made of the strengths and weaknesses of Catholic contributions to the general ethical and particular bioethical debates that permeate the course of this thesis. In the three succeeding components of this historical review I deal with (1) the biblical understanding of the moral life as it has been articulated in Catholicism; (2) with the chief elements of moral explanation from biblical times to Vatican Council II, and (3) with an eye to the domain upon which this thesis is focused, upon the development of these ideas since Vatican II.

6.1.1.1 The Bible and the Moral Life

The ethical teaching of the Old Testament is neither homogeneous nor consistent, spanning as it does an extended period of time and a variety of literary genres. It draws no sharp distinction between ethical and religious teaching and conduct. It is important to note the central role of the covenant in the religious and moral experience of Israel, expressed by a range of social origins, social structures, personal and group experiences as significant for the development of Old Testament moral teaching.[5] The primary reality is Israel's experience of the living God who reveals himself as a God of love and mercy.[6] This experience invites people to respond with a total life-style and outlook that is appropriate to this relationship.[7] The people of

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infancy. All moral theologians prior to these developments were clerics engaged in the work of education of priests in seminaries

5 Cf. J. L. McKenzie, "Aspects of Old Testament Thought" in *The New Jerome Biblical Commentary*, edited by R. E. Brown, J. A. Fitzmyer, and R. E. Murphy, (London: Geoffrey Chapman, 1990), 1295-1301. Allen observes that "covenants imply strong affirmation of each member in the relationship, a focus on the relationship between the members rather than mainly on the stipulated obligations, and emphasis upon mutual belongingness and enduring responsibility, even when the members are unfaithful. Although the obligations of a covenant vary somewhat with the type of relationship, they characteristically stress mutual faithfulness of a kind appropriate to the type of relationship." J. L. Allen, "Covenant" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 136

6 Cf. K. D. Sakenfeld, "Love (OT)" in *The Anchor Bible Dictionary*, edited by D. N. Freedman, Vol. 4, (New York: Doubleday, 1992), 375-80

7 The call-response model of covenant relationship has been emphasised by Bernard Haring and has had a great impact on post-Vatican II moral theology. Cf. B. Haring, *The Law of Christ*, Vol. 1, (Cork: Mercier, 1963), 63-98.

Israel experienced their God in the events of history. The moral emphasis of this people is thus not a philosophy of right living. Rather it is the experience of a personal God in historical events. The moral challenge for Israel was to understand this relationship, to struggle with it and to celebrate it. Their struggle to assert a monotheistic belief grounded much of the moral agenda of the people of Israel.[8] The Ten Words or decalogue encapsulate in apodictic form the response required of this unique relationship with God.[9] Israel is different to all other nations for they are to be "a people holy to the Lord"[10], called "to be holy, for I am holy"[11].

Worship proclaims the mystery of God's holiness - that he is Other and Transcendent.[12]. Two further characteristics of Old Testament morality should be noted here. First, Israelites lived a family based moral life. The duty to honour father and mother underpinned obligations within the family.[13] Patriarchal structures dominated Israel's social life. The continuity of the family line was ensured by the levirate law.[14] This ensured offspring for a deceased man and ensured his memory endured.[15] The responsibilities of a *goel* or redeemer maintained the family structure. A kinsman was obliged to come to the rescue of those family members who had fallen on hard times.[16] Secondly, the Jewish ethos favoured a worldly morality. The good life for the Israelite comprised a big family, living to a ripe old age, enjoying the respect of one's fellow human beings and acquiring sufficient wealth to be comfortable and secure.[17] The criticism of the prophets of injustice in trading practices and oppression of the poor remained a constant theme throughout the Old Testament period.[18] Concern for the poor and marginalised who lived precariously on

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8 In Romans Paul argues that all human sinfulness and social dissolution derives from a denial of belief in the one God. (Rom.1:16-32)

9 Ex.20:1-17; Dt.5:6-21. The apodictic law of the decalogue contextualised the casuistry of the covenant code (Ex.20:23-23:33) and the holiness code (Lv.17-26).

10 Dt.14:2

11 Lv.11:44

12 "You have been told, O man, what is good, and what the Lord requires of you: only to do right and to love goodness, and to walk humbly with your God ." Mic.6:8

13 Ex.20:12; Dt.5:16

14 Dt.25:5-10; Rth.3:9-13;4:1-13

15 This was particularly important for a society that did not believe in an after-life. The latter belief developed only late in Judaism (2 Macc.7).

16 To avenge him if murdered (Dt.19:4-12; Jos.20), to redeem property that had been sold (Lv.25:25ff.) or family members who had been sold into slavery (Lv.25:47ff.)

17 The life experience of Job well illustrates these priorities as well as the discordance in his understanding as to why God should punish a good man. For an interesting contemporary discussion of this issue see H. Kushner, *When Bad Things Happen to Good People*, (London: Pan Books, 1981)

18 The pre-exilic prophets frequently denounced injustice: Am.5:7;6:12; Is.5:7,23; Jer.22:13,15.

the edge of a society without any social security net is well illustrated by the rules regarding the harvesting of crops. The poor were to be able to scavenge the stubble and left overs.[19] In summary, the key features of the Old Testament ethic is that God is experienced in history, that the experience calls for a response and that the response is worked out in a family that is engaged in the world.

The New Testament is continuous with the teaching of Israel in the Old Testament in that "morality is rooted in religious faith, and the latter is always understood as including a moral demand because God is apprehended as righteous will."[20] Jesus was not primarily a teacher of morality. The ethic of Jesus, and that of the New Testament as a whole, is best understood as an ethic of human response to God's action in establishing the promised reign of God in the person and work of Jesus. The proclamation of the *basileia* - the reign or kingdom of God - is the central message of Jesus.[21] The call is to repentance and faith.[22] While Jesus acknowledged the Jewish moral teaching he went beyond it intensifiying, radicalising and universalising its demands.[23] The ethic of the kingdom describes the reign of God that will prevail when the kingdom is fully established.[24] Two elements of the gospel teaching about the moral life require attention at this point. First, each of the gospel narratives gives incidents early in Jesus' public ministry where he calls disciples.[25] The call is to a personal relationship with Jesus that entails a more profound listening to his message by the disciple and a faithful following in his way even if this should lead to

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19 Lv.19:9-10; 23:22; Dt.24:19-21

20 E. C. Gardner, "New Testament Ethics" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 421

21 Mt.1:15

22 "'Repentance' translates a Greek work *metanoia* which is much richer in its signification than the English. Its chief Old Testament antecedent is a Hebrew word *shuv*, whose literal meaning is to return to the place from which one has set out - that is to God. When Jesus called for repentance he was calling on people to turn about, to re-orientate their lives, to make a fresh beginning, to go back to God." P. Hannon, *Church, State, Morality and Law*, (Dublin: Gill and Macmillan, 1992), 34. Cf. R. Schnackenburg, *The Moral Teaching of the New Testament*, (London: Burns & Oates, 1975), 15-53; F. Bockle, *Fundamental Moral Theology*, (Dublin: Gill and Macmillan, 1980), 152-157

23 Mosaic prohibitions against killing and adultery now include attitudes of anger and lust (Mt.5:21-22, 27-28). The traditional demands of forgiveness are now unlimited (Mt.18:21-22) and the principle of retaliation gives way to the call to turn the other cheek (Mt.5:38-39). The commandment of neighbour love is now to include one's enemies (Mt.5:43-48).

24 This indicates the present and future dimensions of the reign of God. Note the dimension of realised and future eschatology in the gospel of John and the discussion of eschatological ethics in recent literature. Cf. C. E. Braaten, *Eschatology and Ethics*, (Minneapolis: Augsburg, 1974); E. C. Gardner, "Eschatological Ethics" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 201-5

25 Mt.4:18-22; Mk.1:16-20; Lk.5:1-11

suffering and death.[26] The community of life with the historical Jesus that the disciples experienced (designated *koinonia*[27] in later N.T. writings) is a sign of the kingdom and enabled them to absorb his attitudes to life[28] particularly his profound obedience to the Father and his love for the neighbour.[29] John expresses this in rich and varied language. The disciple is now the friend of Jesus[30], participant in a relationship of mutual indwelling[31] such that he or she now lives as in the light.[32]

The second aspect to note is that Matthew presents Jesus as the teacher of morality especially in the diverse sayings of the Sermon on the Mount.[33] Three elements of the Sermon are relevant to our discussion. First, Jesus calls his disciples to a radical life in the Spirit. This is epitomised by the beatitudes.[34] Second, the Christian call to prayer, almsgiving and fasting[35] expresses in concrete behaviour the two great commandments of love of God and neighbour.[36] Finally, the lived response of a follower of Jesus arises from deep within the interior life of the person.[37]

This sketch of the gospel teaching is vital for the argument of this thesis. It situates the specifically ethical components of Christian discipleship in a theological, relational and communitarian context. This is particularly the case in the writings of

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26 "Come and see", Jn.1:39. For a detailed study of this text see R. E. Brown, *The Anchor Bible: The Gospel According to John (i-xii)*, (Garden City, N.Y.: Doubleday & Co., 1966), 73-80. Mk.8:34: "If anyone wants to be a follower of mine, let him renounce himself and take up his cross and follow me." Cf. Lk.9:57-62

27 Cf. R. W. Wall, "New Testament Koinonia" in *The Anchor Bible Dictionary*, edited by D. N. Freedman, Vol. 1, (New York: Doubleday, 1992), 1103-10

28 The question of conduct was raised when Jesus was criticised for eating a meal without the customary washing beforehand (Mt.15:2, 20; Mk.7:2,3), for eating with Levi the tax collector, with people considered to be sinners or outcasts

29 Jn.6:38; cf. Mt.26:39; Heb.5:8; 10:5-10

30 Jn.15:15: "I shall no longer call you servants...I call you friends.."

31 Jn.15:4: "Remain in me, as I in you. As a branch cannot bear fruit all by itself, unless it remains part of the vine, neither can you unless you remain in me." See also 1 Jn.4:7-5:4

32 Jn.8:12: "I am the light of the world; anyone who follows me will not be walking in the dark but will have the light of life." See also 1 Jn.1:5-7

33 As Meier aptly observes in his study of Matthew "Christ is a teacher in a unique way, for what he teaches depends on his own person for its truth, validity and permanence. Teacher and teaching become inextricably bound together." J. P. Meier, *The Vision of Matthew*, (New York: Paulist, 1979), 43. Cf. H. K. McArthur, *Understanding the Sermon on the Mount*, (London: Epworth, 1961), 105-127

34 Schnackenburg, *The Moral Teaching of the New Testament*, 54-89. See also M. D. Hamm, *The Beatitudes in Context. What Luke and Matthew Meant*, (Wilmington, Delaware: Michael Glazier, 1990); J. Dupont, *Les Beatitudes*, Vol. 2-3, (Paris: Gabalda, 1969-1973)

35 Mt.6:1-18

36 Mt.22:34-40; Mk.12:35-37; Lk.20:41-44

37 This is well expressed in the antitheses of Mt.5:20-48.

Paul who offers many directives regarding concrete moral behaviour.[38] This teaching, however, makes little sense divorced from Paul's foundational teaching on faith and baptism.[39] The new status as believer makes the Christian part of a new community.[40] Contemporary Catholic thinkers point to Paul's transcendental moral teaching - exhorting us to keep the reign of God ever before our minds[41], conscious we are a new creation in Christ[42] and called to be faithful, hope-filled and loving people[43]. This is the background against which his categorical moral teaching is to be evaluated. Paul attempts to address particular moral issues and to concretise the absolute imperative to neighbour love in relation to topics as diverse as the eating of food sacrificed to idols and the scandal caused to the weak of faith[44]; prohibitions against false worship[45] and impurity in any form[46]; prescriptions about the Christian's relationship to secular authority[47]; directives regarding domestic[48] and community order.[49]

In the later writings of the New Testament concern arises regarding the Christian community's relationship with the pagan world. In Rom.13:1-7 Paul enunciates the principle that all lawful authority derives from God. Christianity is not in opposition to civil life and the Christian is not absolved from the duties and obligations of a citizen.[50] The fundamental Christian attitude to the pagan world arose from Jesus' exhortation to give to Caesar the things that are Caesar's and to God the things that

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38 Cf. Schnackenburg, *The Moral Teaching of the New Testament*, 261-306; W. Schrage, *The Ethics of the New Testament*, (Edinburgh: T & T Clark, 1988), 163-239; R. F. O'Toole, *Who Is a Christian? A Study in Pauline Ethics*, (Collegeville: The Liturgical Press, 1990); V. P. Furnish, *Theology and Ethics in Paul*, (Nashville: Abingdon Press, 1968); J. A. Fitzmyer, "Pauline Theology" in *The New Jerome Biblical Commentary*, edited by R. E. Brown, J. A. Fitzmyer, and R. E. Murphy, (London: Geoffrey Chapman, 1990), 1382-1416.

39 Rom.5-6

40 Gal.3:25-29; 1 Cor.12 speaks of the variety and unity of gifts that form a community after the analogy of the human body.

41 1 Thess.2:12; Rom.13:11-12

42 2 Cor.5:17; Rom.6:3-4, 12-13; 12:2; Eph.4:1-2

43 Gal.6:2; 1 Cor.12:31-13:13; 2 Cor.5:14-15

44 1 Cor.8:1-13; l0:23-11:1; Rom.14:1-15:6

45 1 Cor.10:7,14

46 1 Thess.4:3; Gal.5:19; 2 Cor.12:21; Rom.1:24;6:19; 1 Cor.6:12-20

47 Rom.13:1-7

48 Col.3:18-4:1; Eph.4:1-6:17;

49 The deutero-Pauline texts: 1 Tim.2:1-3:13; Tit.2:1-10;3:1-7

50 This principle was still maintained after the persecutions. Cf. Tit.3:1; 1 Tim.2:1-2. Emperor worship was viewed as blasphemous (cf. Rev.13:4-8,15; 14:9, 11; 16:2; 19:20) and Christians must be willing to accept sufferings, imprisonment and death (Rev.13:10) with the conviction that they will triumph with Christ in the end (Rev.20:4)

are God's.[51] Christian behaviour should be outstanding such that pagans are led to acknowledge the God of the community.[52]

The teaching of the New Testament has constantly engaged the Christian community as it has confronted each new era throughout history. The dialogue between the Church living in the world has sought to understand and interpret the foundational teachings of the canonical scriptures. This is well illustrated in the historical survey that follows.

6.1.1.2 An Evolving Moral Exploration

A number of elements appeared in the evolving moral exploration of the Church up until the renewal of moral theology initiated by the Second Vatican Council. First, much moral thinking has developed out of Christian ministry and the moral requirements of the Christian life.[53] In the early centuries Christian existence in a pagan and often hostile environment posed many challenges, such as conscription for military service, reconciliation of apostates, forgiveness for capital crimes. Second, philosophical thought was used in the defence of the faith and in developing theological explanations of the central mysteries of Christianity. Throughout the so-called patristic period rational frameworks were adopted from secular philosophical thought, particularly Platonism, and transformed in the biblical studies, homilies and theological treatises directed to the instruction of Christian communities.[54] The Church in the East developed its moral instruction from the sacred mysteries.[55] This differed greatly from the more practical and sober teaching of the western Church. The eastern emphasis on knowledge and contemplative reflection was replaced in the West by detailed analysis of the human will and action in the writings of Tertullian, Ambrose and Augustine. The grace of redemption that enabled Christians to live the

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51 Schnackenburg, *The Moral Teaching of the New Testament*, 243-244.

52 1 Pt.2:11-17; Tit.3:1-2

53 Cf. G. Angelini and A. Valsecchi, *Disegno storico della teologia morale*, (Bologna: Dehoniane, 1972); Ph. Delhaye, "La morale des Peres", *Seminarium* 23 (1971): 623-38; T. Deman, *Aux origines de la theologie morale*, (Montreal: Institut d'Etudes Medievales, 1951); E. Luthardt, *History of Christian Ethics*, Vol. 1, History of Christian Ethics before the Reformation, (Edinburgh: T & T Clark, 1889); F. X. Murphy, "The Background to a History of Patristic Moral Thought", *Studia Moralia* 1 (1963): 49-85; E. Osborn, *Ethical Patterns in Early Christian Thought*, (Cambridge: Cambridge University Press, 1976).

54 The *two ways* doctrine is first developed in the *Didache* (c. 90 A.D.). Apologists such as Justin Martyr (d. 165 A.D.) defended Christianity as a superior way of life against the vices of the pagan world. Clement of Alexandria (d. 220 A.D.) and Origen (d. 254 A.D.) absorbed the prevailing Greek modes of thought and put them at the service of Christian teaching.

55 The *Mystagogic Catecheses* of Cyril of Jerusalem (d. 386 A.D.) are an example. Cf. G. V. Lobo, *Guide to Christian Living: A New Compendium of Moral Theology*, (Westminster, Md.: Christian Classics, 1984), 3. For a detailed study see Luthardt, *History of Christian Ethics*, 107-284.

new Way dominated the Latin Church's approach to morality. The result was a morality determined by objective and ecclesiastical conditions.[56] Third, the missionary expansion of the Irish monks on mainland Europe during the sixth to tenth centuries reinforced an objectivist understanding of morality. This evolved in the pastoral practice of individual confession and the use of penitential books by confessors.[57] Fourth, for a brief period in the High Middle Ages moral theory was integrated within a comprehensive theological world view.[58] This quickly broke down following the work of William of Ockham (d.1359).[59] Ockham's epistemology denied universals and consequently withdrew almost all the data of faith from the realm of reason. His emphasis on the omnipotence and mercy of God gave central place to the divine will in relation to human life. All morality thus consists in the human person's free obedience to the divine law.[60] The individualism implicit in

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56 The eastern church differed from that of the west emphasising the contemplative and mystical dimensions of the Christian life. T. Spidlik, "Moral Theology and Spirituality, Greek Orthodox" in *New Catholic Encyclopedia*, Vol. 9, (New York: McGraw-Hill, 1967), 1126-28. Augustine of Hippo (d.430) has been one of the most influential figures for the history of moral reflection in the Roman Church. Cf. J. Mahoney, *The Making of Moral Theology. A Study of the Roman Catholic Tradition*, (Oxford: Clarendon, 1989), 37-71. For a concise outline of Augustine's moral teaching see J. P. Wogaman, *Christian Ethics. A Historical Introduction*, (London: SPCK, 1994), 51-60. In the centuries following his death only the *Moralia in Job* of Gregory the Great (d.604 A.D.) exercised comparable influence mainly through the monastries and their schools. "It was considered enough, especially in Benedictine cloisters, to reread the Fathers, to make extracts from their selected writings according to a practical point of view, as did, for example, Rabanus Maurus (d.859). To reconstruct the moral theology of the period one has to have recourse to the decrees of the popes, the councils and bishops, made in the effort to remedy abuses and thereby raise the moral level of the Christian people." L. Vereecke, "Moral Theology, History of (700 to Vatican Council I)", in *New Catholic Encyclopedia*, Vol. 9, (New York: McGraw-Hill, 1967), 1119-22. For more detailed studies of the period see H. Maisonneuve, *La morale chretienne d'apres les Conciles des Xe et XIe siecles*, (Louvain: Ed. Nauwelaerts, 1935); F. O. Vandenbroucke, *Pour l'histoire de la theologie morale: La morale monastique du XIe a XVIe siecle*, Analecta Mediaevalia Namurcensia, 20 ed., (Louvain: Nauwelaerts, 1966). Contemporary Roman Catholic theology in the west is now returning to the rich theological heritage of the east.

57 "They enabled the confessor to determine the specific kind of sin being confessed. They facilitated his questioning of the penitent and guided him in the imposition of the appropriate punishment". J. A. Gallagher, *Time Past, Time Future: An Historical Study of Catholic Moral Theology*, (New York: Paulist Press, 1990), 8

58 The *exitus-reditus* framework of Aquinas's *Summa Theologiae* joined the doctrine of God (part I) to the moral teaching of part II and the exposition on the sacramental life in part III. Cf. J. A. Weisheipl, *Friar Thomas d'Aquino. His Life, Thought and Work*, (Oxford: Blackwell, 1975)

59 E. Gilson, *History of Christian Philosophy in the Middle Ages*, (London: Sheed & Ward, 1972), 489-498; A. Pinckaers, "Ockham and the Decline of Moral Theology", *Theology Digest* 26 (1978): 239-41; F. C. Copleston, *A History of Philosophy*, Vol. 3, Ockham to Suarez, (London: Burns, Oates & Washbourne, 1953), 43-121; F. C. Copleston, *A History of Medieval Philosophy*, (London: Methuen, 1972), 230-276

60 "The influence of Nominalism was great, especially in methodology, which in moral science opened the doors to casuistry." Vereecke, "Moral Theology...," in *New Catholic Encyclopedia*, 1120. Two earlier influences with a lasting impact on medieval thinking must be noted: (1) the

nominalist thinking created an intellectual environment receptive to the legalism that subsequently developed and flourished in different forms of casuistry.[61] The latter was act-centred and intensely preoccupied with the conscience of the moral agent.[62] Fifth, the discovery of the new world challenged Catholic moral theory with a range of radically new questions: the rights of South American Indians and questions of international law, inflation in monetary economies and issues of justice.[63] Sixth, moral theology continued to be shaped by the pastoral needs of the Church. The training of clergy initiated by the reforms of the Council of Trent (1545-1563) necessitated textbooks to equip them for their ministry. This preparation was to take place within a seminary.[64] Courses of systematic moral analysis evolved into manuals of moral theology.[65] This body of literature held sway in seminaries up until the 1960s.[66] Separation of moral thinking from biblical and dogmatic theology shaped the methodology of the discipline.[67] The manuals continued the Church's

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growth of canon law following the *Decretum* of Gratian (1140 A.D.) and (2) the rediscovery of Aristotle's *Nicomachean Ethics* and its use in theology

[61] Casuistry is "the method of bringing general moral principles or norms to bear on particular cases for the purposes of informing conscience and guiding conduct." "Casuistry" in *The HarperCollins Encyclopedia of Catholicism*, edited by R.P.McBrien, (New York: HarperCollins, 1995), 234; A. R. Jonsen and S. Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning*, (Berkeley: University of California Press, 1988), 137-175

[62] Casuists evolved a number of approaches, e.g. probabilism, laxism, that provoked heated controversies. One of the most influential writers who sought to find a middle way that was pastorally sensitive to the needs of people was Alphonsus Liguori (1696-1787). Another significant influence in the life of the 17th. century church was Jansenism. It was to exert considerable influence in the French church and Irish Catholicism up until recent times. The rigorous piety and theology of Jansenism began with the work of Baius (d.1589) and gives evidence of the enduring influence of Augustine and Nominalism. The most famous attack by a Jansenist on the perceived laxist moral teaching of the Jesuits is to be found in Blaise Pascal's *Provincial Letters*.

[63] At the University of Salamanca in Spain noted Dominican thinkers such as Francesco de Vitoria (1483-1546), Melchior Cano (1509-1560), Bartolomeo de Medina (1527-1580) and Domingo Banez (1528-1604) laid the basis of a theological renewal that was to bear fruit in the decrees of the Council of Trent (1545-1563). Use of the *Summa theologiae* of Aquinas at Salamanca together with the introduction of dictation as a classroom method, e.g. the *reportata, reportationes* of Vitoria's classes, ensured a systematic and detailed study of the text. It also assisted in the spread of the new theology prior to the printing press.

[64] Cf. Gallagher, *Time Past, Time Future*, 29-47; J. Delumeau, *Catholicism between Luther and Voltaire: A New View of the Counter-Reformation*, (London: Burns & Oates, 1977), 31-34

[65] One of the earliest publications from the *cursus maior* based on the *ratio studiorum* of the Society of Jesus was that of Joannes Azor (1603) called the *Institutiones morales*. It was somewhere between the speculative theological *summas* used in the universities and the extant *summas* for confessors. For a detailed outline of the early development of the moral manuals see J. Theiner, *Die Entwicklung der Moraltheologie zur eigenstandigen Disziplin*, (Regensburg: Verlag Friedrick Pustet, 1970)

[66] For a succinct outline of the history of the manuals and their theology see Gallagher, *Time Past, Time Future*, 29-97

[67] Melchior Cano in his *De locis theologicis*, books 2-11, studied ten theological *loci* which he designated as scripture, oral tradition, the Catholic church, the councils, the Roman church, the

preoccupation with objective morality and the obligations deriving from law, both divine and human.

This brief survey indicates a number of characteristics of Catholic moral theory through the centuries: it developed in the service of the Christian moral life; was motivated by pastoral concern; reached out to other disciplines to provide a rational basis for its teaching; emphasised the objective nature of morality; was best understood within a wider theological world-view; attempted to confront new issues and was concerned with the personal formation and moral lives of all in the Church. Catholic moral theory did not manifest these characteristics uniformly throughout the last twenty centuries. In recent times the radical changes of the contemporary world have contributed to a re-appraisal of the Church's self-understanding and mission. The Second Vatican Council gave impetus to this process.

6.1.1.3 Vatican II to the Present

Vatican Council II (1962-1965) was a watershed in the evolving discipline of moral theology.[68] In its directives for the formation of future clergy the Council required that

> special care should be given to the perfecting of moral theology. Its scientific presentation should draw more fully on the teaching of holy Scripture and should throw light upon the exalted vocation of the faithful in Christ and their obligation to bring forth fruit in charity for the life of the world.[69]

In this text we have the essential elements of the renewal process that continues to this day. The source of Christian moral teaching is the bible.[70] Christian life is essentially a gift from Christ and is the fruit of the Spirit.[71] In responding to the call of Christ[72] the individual Christian lives his or her life of faith[73] and love[74] in the

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Fathers, theologians, natural reason, philosophers, human history. For a detailed study see E. Marcotte, *La nature de la theologie d'apres Melchior Cano*, (Ottawa: Editions de l'Universite, 1949). The influence of nominalist and Augustinian themes continued throughout the post-Reformation period with the proliferation of *De iustitia et iure* tracts. Cf. Mahoney, *The Making of Moral Theology*, 224-231

68 Ph. Delhaye, "The Contribution of Vatican II to Moral Theology", *Concilium* 8 (1972): 58-67

69 *Optatum totius*, n.16 in A. Flannery, ed., *Vatican Council II. The Conciliar and Post Conciliar Documents*, (Dublin: Dominican Publications, 1981), 720

70 *Dei verbum*, n.25 in Flannery, *Vatican Council II*, 764-765

71 *Lumen gentium*, n.7 in Flannery, *Vatican Council II*, 354-356

72 *Lumen gentium*, n.31 in Flannery, *Vatican Council II*, 388-389

73 *Dignitatis humanae*, n.10; *Dei verbum*, n.5; *Gaudium et spes*, n.21 in Flannery, *Vatican Council II*, 806-807, 752, 920-922,

74 *Gaudium et spes*, n.24; *Apostolicam actuositatem*, n.13 in Flannery, *Vatican Council II*, 925, 781-782

context of a pilgrim community.[75] Each Christian and the entire Church community must be open to the intrinsic value of the world and the goodness of the universe.[76] Moral theology today, to be true to the orientation given it by Vatican II, must be grounded in the search for human values[77] and must develop the implications of this search into a Christian anthropology.[78]

The most significant catalyst in the renewal of moral theology since Vatican II has been the encyclical *Humanae vitae* (1968). Its impact has been at both the level of lived experience and that of systematic moral reflection.[79] The papal ruling on contraception has had ever wider repercussions. Heated discussion on sexual morality, marriage and family, the role of natural law argumentation, the contribution of behavioural sciences to moral reasoning, the nature of moral norms and the role of the teaching authority of the Church, the exercise of personal conscience and the right to dissent are but some of the areas in contemporary Catholic moral theology that have been subjected to intense debate during the last quarter century.

The most noteworthy change of emphasis in the period since the end of the recent Vatican Council has been that from a *classicist* world view to an *historically conscious* world view.[80] The manualists best illustrate the former approach with their emphasis on the static, the immutable, the eternal. Their methodology tended to be abstract, a priori and deductive. More recent approaches have emphasised the changing, developing and evolving aspects of human living with a methodology that is concrete, a posteriori and inductive.[81] An increased concern for the moral agent is closely related to this shift in perspective and methodology.[82] The previous emphasis

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75 *Lumen gentium*, nn.9-17 in Flannery, *Vatican Council II*, 359-369

76 *Gaudium et spes*, nn.34, 40-45 in Flannery, *Vatican Council II*, 933-934, 939-947

77 Ph. Delhaye proposes six reasons in the council documents for the Christian's secular commitment: the fundamental goodness of creation; the dignity of the human person; the service of charity; the *recapitulation* of all things in Christ; Christ's own example; the cosmic relevance of the resurrection. Delhaye, "The Contribution…, " *Concilium*, 65

78 This anthropology proceeds from an understanding of the human person as the image of God (*Gaudium et spes*, n.12) and a renewed appreciation of the common good (*ibid.*, n.26).

79 A survey of the debates surrounding the encyclical may be seen in the *Notes on Moral Theology* in *Theological Studies* 1967-1969 and 1979

80 J. M. Gustafson, *Protestant and Roman Catholic Ethics: Prospects for Rapprochement*, (Chicago: University of Chicago Press, 1978), 46-59; C. E. Curran, "Moral Theology: The Present State of the Discipline", *Theological Studies* 34 (1973): 446-67.

81 C. E. Curran, "How My Mind Has Changed, 1960-1975." *Horizons* 2 (1975): 196; see also N. J. Rigali, "Morality and Historical Consciousness", *Chicago Studies* 18 (1979): 161-68.

82 According to James Gustafson, moralists are finding "there are philosophical and religious reasons for being more concerned about the uniqueness and richness of personal and interpersonal existence." Gustafson, *Protestant and Roman Catholic Ethics*, 55

on an objective order with which human existence must be aligned has given way to a deeper consideration of freedom and personal conscience in the sphere of individual morality. Hand in hand with this goes a richer notion of the common good in social ethics.[83] A third shift of perspective in recent moral theological reflection focuses on the moral evaluation of the complete human situation. This has broadened the earlier somewhat exclusive focus on the individual moral act.[84] A final change in perspective has occurred with a greater pluralism in contemporary moral thinking. A variety of emphases and starting points, different philosophical and theological orientations, greater interdisciplinary research, have all contributed to a more diverse moral theology since 1965.[85] It is fair to say that the present state of Roman Catholic moral theology is markedly different from that which dominated when the Council opened in 1962.[86]

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83 Curran, "How My Mind...," *Horizons*, 197-199.

84 This has been played out in the debate over *proportionalism*; cf. B. Hoose, *Proportionalism. The American Debate and its European Roots*, (Washington, D.C.: Georgetown University Press, 1987)

85 Richard McCormick sketches ten areas of development in post-conciliar moral theology in R. A. McCormick, "Moral Theology 1940-1989: An Overview", *Theological Studies* 50 (1989): 3-24; published also in R. A. McCormick, *Corrective Vision: Explorations in Moral Theology*, (Kansas City, Mo.: Sheed & Ward, 1994), 5-17. On the variety of methodologies now being adopted in moral theology see B. V. Johnstone, "Methodology, Moral" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer, (Collegeville, Minn.: The Liturgical Press, 1994), 597-609.; J. J Mueller,. *What are they saying about theological method?*, (New York: Paulist, 1984). On feminist methodology see G. M. Keightley, "The Challenge of Feminist Theology" in *Horizons on Catholic Feminist Theology*, edited by J. W. Conn and W. E. Conn, (Washington, D.C.: Georgetown University Press, 1992), 37-60; On the methodology of liberation theology see T. L. Schubeck, *Liberation Ethics. Sources, Models and Norms*, (Minneapolis: Fortress Press, 1993)

86 McCormick succinctly describes the present state of moral theology in terms of an age of settling; an age of specialists; an age of justice; an age that emphasises experience, cultural diversity, technology, holiness and witness, theological anthropology, ecumenism, and the place of women. McCormick, *Corrective Vision*, 17-22

6.1.2 Theological Perspectives

6.1.2.1 Faith and Morality

Christians are not distinguished by the fact of having convictions about the good. Rather they are distinguished by the kinds of convictions they have. The Christian is moral because the God revealed in human history gives the Christian a reason for being moral.[87] The conviction about the goodness and presence of God yields a normative statement about the moral life informed by faith. Human moral striving ought to be responsive to God and ought to be governed by what is known of the goodness of God and of God's own activity in the world. From this perspective the question for morality is: *What is God enabling and requiring me to be and to do?* An ongoing personal discernment is a necessary feature of the moral life where the individual seeks to discover the ways that are most responsive to God.[88] The human experience of God is expressed in religion.[89] This seeks to offer ultimate explanations of the meaning and purpose of all reality, especially that of human existence. A religious faith is traditional since, by myths, symbols, rituals and beliefs passed down from one generation to the next, it conveys a distinctive vision of the meaning and purpose of human existence.[90] But what is the nature of this link between God and the moral life? Plato posed the question in *Euthyphro* in the following terms: is an act right simply because God approves it or does God approve it because it is right?[91]

The Christian rationale for the moral life overcomes this dilemma. Behaviour that fulfills the human potential is in accord with the will of God. Three important implications follow. First, the end (human destiny with God) determines the means (human behaviour) and dictates what is right or wrong. Second, much of Christian moral reflection is an empirical matter and third, moral rules and principles are not

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87 "The good is the foundation and the goal of all moral striving. Ethics, then, whether philosophical or theological, must in some way be specific about what the good is and where it can be found. The basic conviction of Christian faith is that God is good. God is the only center of value, the fixed point of reference for Christian morality." R. M. Gula, *Reason Informed by Faith: Foundations of Catholic Morality*, (New York: Paulist, 1989), 43

88 Cf. Gula, *Reason Informed by Faith*, 44

89 Avery Dulles points to various explanations of the link between faith and morality (or justice). Faith may be viewed as (1) *conviction* (the Catholic intellectualist approach); (2) *trust* (the Protestant fiducial approach) or (3) *commitment* (the performative approach of liberation theology). J. C. Haughey, ed., *The Faith That Does Justice. Examining the Christian Sources for Social Change*, (New York: Paulist Press, 1977), 10-46

90 R. Gascoigne, *Freedom and Purpose. An Introduction to Christian Ethics*, (Sydney: E.J. Dwyer, 1993), 29-30

91 For a succinct discussion of different answers to this dilemma see C. S. Layman, *The Shape of the Good. Christian Reflections on the Foundations of Ethics*, (Notre Dame: University of Notre Dame Press, 1991), 31-57

moral reflection is an empirical matter and third, moral rules and principles are not designed to frustrate human nature but to fulfill it.[92] In regard to the first of these implications it is important to note that for the Christian believer

> morality cannot but be closely related to experiences of God and beliefs about God. The Christian cannot do justice to his or her moral experience and moral worldview without seeing all things as being dependent on God and without referring to God in some way as the source and goal of it all. God is the horizon within which the believer sees and values all things. As a result, the morality of those whose imagination is influenced by the religious beliefs of the Judaeo-Christian tradition has a distinctively theological element.[93]

This distinctively theological element provides the *stance* which serves as the starting point of Roman Catholic thinking about the moral life. The five Christian mysteries of creation, sin, incarnation, redemption and resurrection destiny provide the basis and context for Catholic moral reflection.[94] Implicit in this approach is an understanding that all cosmic reality is touched by the saving work of God in Jesus Christ. It follows "that faith ensures the continuity of the transcendent obligatory claim that the categorical structure of morality - in other words, both the contingency of the goods and values involved and the intelligibility of the objective demand involved - continues to be valid."[95]

Central to the moral task is human experience. Human reflection and reasoning are the key instruments by which human beings unpack their personal consciousness of the *ought* or their sense of moral obligation.[96] This personal task takes place, for the Christian, within a community of faith. Recent theological reflection has not only emphasised orthodoxy (in the area of belief) but has focused on orthopraxis (or proper actions) in the Christian community:

> Praxis consists in more than just action. Praxis refers to a way of human knowing in which our actions contribute to our knowledge. Knowledge is not just rationalistic, conceptual, and the result of observaion by a neutral, noninvolved party. In this perspective not only are actions important but they also contribute to the human knowing process.[97]

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92 Layman, *The Shape of the Good*, 56-57

93 Gula, *Reason Informed by Faith*, 45; see also E. McDonagh, *Doing the Truth. The Quest for Moral Theology*, (Dublin: Gill & Macmillan, 1979), 27-38

94 C. E. Curran, *New Perspectives in Moral Theology*, (Notre Dame: Fides, 1974), 56-86

95 Bockle, *Fundamental Moral Theology*, 229

96 E. McDonagh, *Gift and Call: Toward a Christian Theology of Morality*, (Gill and Macmillan: London, 1975), 4-9

97 C. E. Curran, *The Church and Morality: An Ecumenical and Catholic Approach*, (Minneapolis: Fortress Press:, 1993), 12

On this basis the Church views itself as constituting a community of moral discourse "attempting to discern and live out what is in keeping with its self-understanding and mission."[98]

6.1.2.2 The Theological Resources of Moral Theology

Three theological resources are open to the Catholic Christian in confronting the challenges of living faithfully a way of life consistent with the Gospel: the scriptures, tradition and the authority or magisterium in the Church.

Scripture

Vatican II directed that moral theology be renewed by being "more thoroughly nourished by scriptural teaching".[99] In the period prior to Vatican II much moral literature in the Catholic community focused on natural law reasoning and often used the scriptures as a proof-text corroborating conclusions already reached. The last quarter century has seen a more critical approach to the use of scripture in moral theology. Recent authors speak of four tasks, exegetical, hermeneutical, methodological and theological, that confront the moral theologian in his or her use of scripture.[100]

The *exegetical* task seeks to determine the meaning of the text in the original setting.[101] A certain modesty is required when the moral theologian appeals to the bible. Our understanding is limited not only by the evidence necessary to disclose the full context in which the text was expressed but also by the capacity of human language to convey accurately what the original language of the text meant. The *hermeneutical* task involves interpretation, asking what the text means for today. The cultural horizons and presuppositions both *behind* the text, as well as those in the

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98 Curran, *The Church and Morality*, 13

99 *Optatum totius*, n.16; *Dei verbum*, n.24 in Flannery, *Vatican Council II*, 719-721, 763-764. The Church "has always regarded, and continues to regard the Scriptures, taken together with sacred Tradition, as the supreme rule of faith." *Dei verbum*, n.21 in Flannery, *Vatican Council II*, 762. For an outline of the Catholic understanding of scripture as a source of theology see A. Nichols, *The Shape of Catholic Theology: An Introduction to Its Sources, Principles, and History*, (Edinburgh: T. & T. Clark, 1991), 99-162

100 Cf. Gula, *Reason Informed by Faith*, 166-172; K. R. Himes, "Scripture and Ethics: A Review Essay", *Biblical Theology Bulletin* 15 (1985): 65-73; W. C. Spohn, *What Are They Saying About Scripture and Ethics?*, fully revised and expanded edition, (New York: Paulist, 1995); C. E. Curran, "Dialogue with the Scriptures: The Role and Function of the Scriptures in Moral Theology" in *Catholic Moral Theology in Dialogue*, (Notre Dame, Ind.: Fides, 1972), 24-64

101 The current Catholic approach to the use of the scriptures is to be found in The Pontifical Biblical Commission, *The Interpretation of the Bible in the Church*, (Boston: St. Paul Books & Media, 1993)

reader as he or she stands *before* the text, are particularly important in fulfilling this endeavour.[102] Discussions of the *methodological* task distinguish the use of scripture as *revealed morality* from a view of scripture as *revealed reality*.[103] As revealed morality the bible functions as an authoritative guide for judgments and behaviour. Scripture understood as revealed reality, on the other hand, functions by illuminating the human situation, providing a theological framework. This informs the moral life helping us to interpret the presence and action of God and so offers a clue as to what is to be done. In this understanding scripture does not provide specific content for moral judgments. Biblical images provide a context assisting recognition of the action of God and enabing individuals to judge their lives in relation to this. This way of using scripture in moral reflection corresponds to the method sketched by the Council document *Gaudium et spes*. The Church is to scrutinise the signs of the times and interpret them "in the light of the gospel."[104] The fourth and final task for use of scripture in moral reflection is a *theological* one. In this moral theologians seek to determine ways of connecting the bible with other sources of moral wisdom such as personal experience, the example of morally virtuous persons, rational analysis and the teaching authority within the Church. In many cases the ethical material of the bible offers clues, models or ethical orientations that operate as a starting point for developing moral judgment.[105]

Tradition

The task of linking the bible to the present situation demands a creative fidelity that walks a line between the two extremes of fundamentalism and modernism. "Fundamentalism merely repeats the words and formulations of the past. Modernism jettisons the core Christian realities in the light and the purported needs of the times."[106] Some have argued that the recovery of a creative understanding of tradition

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[102] William Spohn advocates a mutually corrective hermeneutic in which the bible shapes our presuppositions while at the same time we admit that our presuppositions shape our understanding of the bible. Spohn, *What Are They Saying*, 56-58

[103] Cf. J. M. Gustafson, *Theology and Christian Ethics*, (Philadelphia: Pilgrim, 1974), 121-145; B. C. Birch and L. L. Rasmussen, *Bible and Ethics in the Christian Life*, (Minneapolis, Minn.: Augsburg Publishing House, 1976), 23

[104] n.4 in Flannery, *Vatican Council II*, 905. This approach has been adopted by the U.S. Catholic bishops in their statements on war and peace and the American economy. The Australian bishops have followed a similar path with their statement on the distribution of wealth, *Common Wealth for the Common Good*

[105] Cf. W. C. Spohn, "Scripture, Use of in Catholic Social Ethics" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer, (Collegeville, Minn.: The Liturgical Press, 1994), 861-74

[106] Curran, *The Church and Morality*, 35. Curran observes that "church today cannot merely repeat the words of Scripture but must try to understand, live, and appropriate the word and work of Jesus in the light of the historical and cultural circumstances of the present. Many different

was one of the outstanding contributions of Vatican II to the Church.[107] The renewal of biblical scholarship has asserted that scripture itself is a product of tradition. Incorporated into the canonical texts of the New Testament are layers of tradition, such as oral (preaching), liturgical (prayer formulae) and narrative sources (recollections of important events such as Jesus' passion). For that reason Vatican II declared that "Sacred Tradition and sacred Scripture make up a single sacred deposit of the Word of God, which is entrusted to the Church."[108] The Council in its documents understood *tradition* in the broad sense of the word. It refers to

> *the whole process by which the Church 'hands on'* (the literal meaning of the word *tradition*) *its faith to each new generation.* This handing on occurs through preaching, catechesis, teaching, devotions, gestures (e.g. the sign of the cross), doctrines, and indeed the Bible itself. In the *narrow meaning* of the term, tradition refers to *the content of the Church's post-apostolic teaching.*[109]

Two elements of this understanding of tradition have a bearing on the argument proposed in this thesis. The first is the Catholic Church's self-understanding as community (its ecclesiology)[110] and, second, the role liturgy has in the living tradition

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theories explain what tradition is and how it functions, but the common element of all who give any role to tradition is the insufficiency of the Scriptures." (*ibid.*, 34). For a systematic exposition of the Catholic understanding of tradition see A. Nichols, *The Shape of Catholic Theology*, 165-231

[107] "Were I asked to state briefly the major theological achievement of the Second Vatican Council, I would unhesitatingly reply: the recovery of *tradition*. There are two inseparable aspects of this. On the one hand, there was the rediscovery, thanks to the careful historical labors of the 1940s and '50s, of rich veins of liturgical and ecclesial tradition antedating the 'traditional Catholicism' of the post-Reformation Church. On the other hand, there was the even more radical realization that tradition is as much process as content (*traditio* as well as *tradita*), and that this process is living, creative, and community-based." A. Dulles quoting R.P. Imbelli in "Vatican II and the Recovery of Tradition" in *The Reshaping of Catholicism. Current Challenges in the Theology of the Church*, (San Francisco: Harper & Row, 1988), 77

[108] *Dei verbum*, n.10 in Flannery, *Vatican Council II*, 755; *Catechism of the Catholic Church*, (Homebush, N.S.W.: St. Pauls, 1994), nn.80-82. It is important to note that this teaching redressed a theological interpretation originating with the Council of Trent. Trent spoke of two sources of revelation, the one written and the other unwritten. Catholic theologians in the Counter-Reformation period understood Trent to mean that scripture and tradition are two separate streams of revelation and that the one (tradition) is the final measure of the other (scripture).

[109] R. McBrien, *Catholicism*, Vol. 1, (East Malvern, Vic.: Dove Communications, 1980), 66. See also *Dei verbum*, n.8 in Flannery, *Vatican Council II*, 754. General usage distinguishes between Tradition (capital "T") as the process of transmission, traditional (small "t", singular) as the content of what is transmitted, and traditions (small "t", plural) as the particular customs of separate churches or movements. Cf. S. Wood, "Tradition" in *The HarperCollins Encyclopedia of Catholicism*, edited by R. P. McBrien, (New York: HarperCollins, 1995), 1261

[110] "[T]he Church, in Christ, is in the nature of sacrament - a sign and instrument, that is, of communion with God and of unity among all men." Vatican II, *Lumen gentium*, n.1, in Flannery, *Vatican Council II*, 350. It is the people of God on a journey to the Father. Cf. *Lumen gentium*, nn.9-17 in Flannery, *Vatican Council II*, 359-69

and moral discernment of the faith community.[111] In this chapter the central importance of the community in its relationship to God has already been emphasised. The Christian ethic is a community ethic in that "it is given to and received in the community, it can be understood only in the community."[112] Two consequences flow from this. The language of moral discourse within the faith community is the medium by which the traditional understanding of the moral life is passed down.[113] Both language and moral content develop over time, indicating the ways tradition is a living and developing reality.

The Church's liturgical life is a second dimension of its living tradition. As the *Catechism of the Catholic Church* states:

> The Church's faith precedes the faith of the believer who is invited to adhere to it. When the Church celebrates the sacraments, she confesses the faith received from the apostles - whence the ancient saying: *lex orandi, lex credendi* (or: *legem credendi lex statuat supplicandi*, according to Prosper of Aquitaine [5th. cent.]). The law of prayer is the law of faith: the Church believes as she prays. Liturgy is a constitutive element of the holy and living Tradition.[114]

In recent times the influence of liturgy on the moral reflection of the Church is being appreciated more widely[115]:

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111 In recent philosophical ethics the role of tradition has received increasing attention. Jeffrey Stout observes that those "most deeply influenced by Hegel - philosophers like Hans-Georg Gadamer and Alasdair MacIntyre, theologians like David Tracy - have taken pains to dissociate themselves from a picture of tradition as basically continuous and conservative. For such thinkers, traditions are ongoing conversations or arguments subject to dramatic reversals and, at times, revolutionary innovation. Tradition, for them, far from being opposed to critical reason, is its necessary embodiment." J. Stout, "Tradition in Ethics" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 630-31

112 E. McDonagh, *Invitation and Response: Essays in Christian Moral Theology*, (Dublin: Gill & Macmillan, 1972), 47

113 An early example of this is to be found in the *paraenesis* (exhortations) and the lists of virtues and vices in the letters of St. Paul.

114 n.1124

115 Two strands of thought seem to exercise an influence on this development. The first comes from contemporary Orthodox theologians who emphasise the role of liturgy on the moral life of the church. Cf. C. Yannaras, *The Freedom of Morality*, (Crestwood, N.Y.: St. Vladimir's Seminary Press, 1984), 77-88. The Armenian Orthodox scholar Vigen Guroian proposes that "liturgy provides a vital link between Christian tradition and ethics, shaping their communal meaning and rendering the truth of the Christian faith persuasive." V. Guroian, *Ethics after Christendom. Toward an Ecclesial Christian Ethic*, (Grand Rapids, Mich.: William B. Eerdmans Publishing, 1994), 33. He agrees with A. Schmemann that "the contemporary crisis of Christian faith is wrapped up with the privatization and disintegration of Christian worship. In a similar vein, I would argue that one of the reasons Christian moral arguments seem so ungrounded these days is that they have become utterly dislocated from Christian worship and liturgy...I believe we would do well to engage in more serious reflection on the relationship between tradition and ethics in light of the *lex orandi.*" (*ibid.* 38-39). The second strand of influence appears to come from contemporary communitarians (e.g. Robert Bellah et al. in the *Habits of the Heart*), and the work

> Participation in the sacramental life of the church can introduce people to a symbol system that challenges many of the wider culture's values while providing an expression of communal values which need to be retained. Through its public prayer the church offers to people rituals that permit formation and ongoing reappropriation of one's identity through the ability of the rites to incorporate participants into a community of tradition. This transformative and educational role of liturgy is a neglected resource for moral theology.[116]

The Church community influences character in three ways: as shaper of moral identity, bearer of moral tradition and as a community of moral deliberation. Where moral identity is concerned it is clear that the Church's liturgy functions as a socializing force.[117] In liturgy celebration, remembering, identity and mystical experience are to be found. These same four elements occur in the moral life. In moral activity we celebrate others, achieve fuller self-identification and self-transcendence. The moral response to a human "other" has the potential to be an encounter with the Divine "Other". Both liturgy and moral action open human beings to the experience of God as the Father of Jesus Christ.[118]

Magisterium

The Church from its beginning was aware of its mission to preach and teach.

> Go, therefore, make disciples of all the nations; baptise them in the name of the Father and of the Son and of the Holy Spirit, and teach them to observe all the commands I gave you. And know that I am with you always; yes, to the end of time.[119]

The *magisterium* of the Roman Catholic Church is its teaching office. While many in the Church exercise a true teaching function (such as catechists, religious educators, preachers, theologians), this prerogative resides in a special way with the pope, and with the bishops in union with the pope.[120] To understand some of the contemporary

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of A. MacIntyre on tradition. S. Hauerwas has become a theological proponent of MacIntyre's approach.

116 K. R. Himes, "The Contribution of Theology to Catholic Moral Theology" in *Moral Theology: Challenges for the Future. Essays in Honor of Richard A. McCormick*, edited by C. E. Curran, (New York: Paulist, 1990), 68-69

117 J. Miller, "Ethics within an Ecclesial Context", *Angelicum* 57 (1980): 32-44. For a similar approach see E. McDonagh, *The Making of Disciples: Tasks of Moral Theology*, (Wilmington, Delaware: Michael Slazier, 1982), 38-59. For a review of McDonagh's approach see R. A. McCormick, "Notes on Moral Theology: 1980", *Theological Studies* 42 (1981): 90-100.

118 The mystical dimension.

119 Mt.28:19-20 (JB trans.); cf. Mk.16:15-16; Lk.24:47-48

120 *Catechism of the Catholic Church*, nn.888-892

debates regarding the magisterium and issues of morality it is important to place them in an historical perspective.[121]

In the early Church there were *didaskaloi* (Greek for *teachers*) whose activity was primarily catechetical. In the second and third centuries theological speculation developed within different schools. From this period, too, it was the *cathedra*, or chair, that signified the role of the bishop as the guarantor of the transmission of the apostolic message. This was not conceived of as a juridical authority. The tradition or transmitted truth was the true authority. By the time of Aquinas, however, a distinction was being made between two teaching authorities: the one pastoral (the office of bishop) the other scientific (that of the theologian). The process of centralising the teaching authority of the bishop of Rome gained momentum during the last century. The encyclical *Humani generis* (1950) of Pius XII was the high-water mark of this centralising tendency. He taught that once the pope expresses a judgement on a debated matter further theological debate is closed.[122] In light of the status attributed to the papal magisterium recent attention has focused primarily on the level of authority statements are claimed to have and the response Catholics should give to such teaching.[123]

Vatican II exhibited a sensitivity to history and consequently did not present the Church with any single paradigm of the magisterium. Nevertheless, it would appear that the Council adopted a view of the magisterium that is predominantly pastoral in character.[124] The primary task of the bishops is to proclaim the apostolic faith and to

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121 R. A. McCormick, "Magisterium and Morality" in *The HarperCollins Encyclopedia of Catholicism*, edited by R. P. McBrien, (New York: HarperCollins, 1995), 807-8. See also C. E. Curran and R. A. McCormick, *Readings in Moral Theology No: 3: The Magisterium and Morality*, (New York: Paulist, 1982)

122 Cf. R. A. McCormick, *The Critical Calling: Reflections on Moral Dilemmas since Vatican II*, (Washington: Georgetown University Press, 1989), 163-70 discusses the meaning of Pius XII's statement and applies it to teachings of Paul VI and John Paul II regarding contraception.

123 "Bishops who teach in communion with the Roman Pontiff are to be revered by all as witnesses of divine and Catholic truth; the faithful, for their part, are obliged to submit to their bishops' decisions, made in the name of Christ, in matters of faith and morals, and to adhere to it with a ready and respectful allegiance of mind. This loyal submission of the will and intellect must be given, in a special way, to the authentic teaching authority of the Roman Pontiff, even when he does not speak *ex cathedra* in such wise, indeed, that his supreme teaching authority be acknowledged with respect, and that one sincerely adhere to decisions made by him, conformably with his manifest mind and intention, which is made known principally either by the character of the documents in question, or by the frequency with which a certain doctrine is proposed, or by the manner in which the doctrine is formulated." *Lumen gentium*, n.25 in Flannery, *Vatican Council II*, 379

124 "The third chapter of *Lumen gentium*, which deals with the hierarchical authority of popes and bishops, stands in some tension with the second and fourth chapters, which deal more positively with the inalienable powers of the laity as active witnesses to the faith. Even within the third chapter, the new doctrine of episcopal collegiality is simply set alongside the monarchical

enable all in the Church to assimilate the values of the tradition so that these might be made present in our world in word and deed. Only secondarily does the responsibility of the hierarchy include the juridical function of determining when error and heresy are present. The hierarchy exercises its responsibility to affirm, protect and promote the moral implications of the apostolic faith in three main ways. The first is to see that the teaching of the Church is provided by others. Secondly, it decides which teachers and teachings are in conformity with the Church's tradition and thirdly, it teaches by instruction.[125] To focus solely on the episcopal or papal magisterium as the only teaching authority in the Church is to ignore the wider picture to be found in the Pastoral Constitution on the Church in the Modern World (*Lumen gentium*). There are a number of complementary teaching authorities in the Church: the prophetic charism that includes the competencies of all especially with experience in particular areas, the doctrinal-pastoral charism of the hierarchy and the scientific charism of the theologian.[126]

Two aspects of the contemporary discussions regarding the magisterium on moral matters are of concern here. First is the question of the competence of the teaching authority of the Church regarding particular moral behaviour and particular moral norms. The question has been raised whether the same level of clarity, universality, and evidential force should be expected in moral questions as in matters of faith? Magisterial authority on moral matters is analogous, not univocal, to its competence in matters of faith. Morality does not *belong* to the Church since it does not rest on revelation but on human nature, conscience and common wisdom. Faith comes from hearing the proclamation of the gospel while moral teaching comes from hearing a much wider chorus of voices.[127]

It follows, therefore, that treating disagreement over moral matters as if disagreements over belief were involved ignores the analogous differences between the two subject matters and the respective competencies of the Church in addressing

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papalism of Vatican I without any genuine reconciliation." A. Dulles, *A Church to Believe In. Discipleship and the Dynamics of Freedom*, (New York: Crossroad, 1987), 116. The *Catechism of the Catholic Church*, nn.2032-2040, appears to have taken a more conservative approach on this matter.

[125] Gula, *Reason Informed by Faith*, 205-206; see also Gascoigne, *Freedom and Purpose*, 183-197

[126] R. A. McCormick, "The Teaching Role of the Magisterium and of Theologians", *Catholic Theological Society of America Proceedings* 24 (1969): 239-54; for a survey of McCormick's thought on the matter see C. E. Curran, *The Living Tradition of Catholic Moral Theology*, (Notre Dame, Ind.: University of Notre Dame Press, 1992), 103-133

[127] Cf. N. J. Rigali, "Moral Theology and the Magisterium", *Horizons* 15 (1988): 122; see also J. Fuchs, "The Magisterium and Moral Theology", *Theology Digest* 38 (1991): 103-7.

them.[128] Recently moralists have suggested that the Church possesses a different degree of competence where matters of moral *goodness* are involved. This is to be distinguished from competence regarding moral *rightness*.[129] "Because *right and wrong*, which pertain to the guidance of particular actions, are of secondary concern for salvation, the Church does not have the same competence on these questions as it does on matters of *good and evil*."[130]

This approach is not universally acceptable. The claim of the *Catechism* appears to contradict the distinction between competencies when it states that the "authority of the Magisterium extends also to the specific precepts of the *natural law*, because their observance, demanded by the Creator, is necessary for salvation."[131] The debate thus focuses on whether the magisterium can teach infallibly regarding concrete moral questions. As McCormick has observed the "question remains a disputed one, but it is hardly very practical since, in the view of most theologians, the magisterium has never taught infallibly on the level of concrete morals, nor would such authority be required for the Church to fulfill its mandate to provide moral guidance."[132]

A second area of contemporary moral debate has focused on dissent from authoritative teachings of the magisterium.[133] Generally dissent has centered on disagreement with one or more aspects of a moral teaching: the accuracy and completeness of the evidence marshaled, the cogency of the argument offered in support or the formulation of the moral position based on the evidence and the

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128 W. C. Spohn, "Notes on Moral Theology:1992. The Magisterium and Morality", *Theological Studies* 54 (1993): 107

129 In the manuals of moral theology the word *good* primarily described human acts. Acts were described as good or bad and people who intended and carried out such acts were likewise described. *Goodness* was not used in the manuals as it is today (after G.E. Moore). Persons are *good or bad*, human acts are *right or wrong*. "The contemporary description of goodness is antecedent to and distinct from the question of rightness. Goodness simply asks whether ones strives our of love or duty to realize right activity. Rightness asks whether the activity itself protects and promotes values. Goodness is not a term of acquittal. If good people perform wrong actions, their primary concern will be to remedy the situation in which harm has been done. Being good they want to do the right." J. F. Keenan, *Goodness and Rightness in Thomas Aquinas's 'Summa Theologiae"*, (Washington, D.C.: Georgetown University Press, 1992), 8

130 Spohn, "Notes on Moral Theology:1992...," *Theological Studies*, 108; see also J. Fuchs, *Christian Ethics in a Secular Arena*, (Washington D.C.: Georgetown University Press, 1984), 131-153

131 n.2036; cf. F. Mobbs, *Beyond Its Authority? The Magisterium and Matters of Natural Law*, (Sydney: E.J. Dwyer, 1997)

132 R. A. McCormick, "Magisterium and Morality" in *The HarperCollins Encyclopedia of Catholicism*, edited by R. P. McBrien, (New York: HarperCollins, 1995), 808

133 Cf. A. Dulles, *The Reshaping of Catholicism: Current Challenges in the Theology of Church*, (San Francisco: Harper & Row, 1988), 93-109; McCormick, *The Critical Calling*, 25-46

argument.[134] The issue of dissent has gained momentum since the encyclical *Humanae vitae* in 1968.[135] During the pontificate of John Paul II efforts have been made to silence and discipline theologians whose teaching has been viewed as offensive or who dissent on particular points.[136] The recent *Instruction on the Ecclesial Vocation of the Theologian* would appear to be directed to the privatisation of theology and the limiting of dissent.[137] This runs contrary to an understanding of theology as a public endeavour. The Christian tradition has always emphasised the centrality of personal conscience and the obligation to follow that conscience even if it should be in error.[138] Efforts have been made to articulate criteria for legitimate dissent. The U.S. bishops view dissent as legitimate under three conditions: when it is (1) based on serious reasons; (2) respectful of teaching authority; (3) not a cause of scandal.[139]

6.1.3 Normative Perspectives

I have argued in the previous sections that Catholic moral theology is radically relational, communitarian and objective. It views the moral life as grounded in an interpersonal relationship with God that transforms our sense of self as moral agent, permeates our relations with other human beings and the entire created universe. Christians view themselves as part of a covenant community that, in continuity with the tradition which, regularly refurbished by the contributions of scripture, tradition and the teaching authority of the Church, seeks to apply the gospel of Jesus Christ to contemporary living. Taken together these factors coalesce into a moral theology that informs, guides and instructs Catholic Christians in their daily living as disciples of

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134 Cf. Gula, *Reason Informed by Faith*, 207

135 Cf. R. A. McCormick, *How Brave a New World? Dilemmas in Bioethics*, (London: S.C.M., 1981), 209-259

136 Charles Curran in the U.S., L. Boff in South America, E. Schillebeeckx in Europe and T. Balasuriya in Asia have all been disciplined

137 The theologian dissenting from magisterial teaching must (1) represent the dissent to magisterial authorities; (2) not state it to the media; (3) remain silent. Congregation for the Doctrine of the Faith, "Instruction on the Ecclesial Vocation of the Theologian", *Origins* 20 (1990): 123. Cf. McCormick, *Corrective Vision*, 100-109; see also the preceding article "Theologians and the Magisterium" (*ibid.* pp.82-99) where he sketches the impact of the present coercive ecclesial atmosphere

138 *Gaudium et spes*, n.16 in Flannery, *Vatican Council II*, 916-917

139 R. A. McCormick, "Dissent" in *The HarperCollins Encyclopedia of Catholicism*, edited by R. P. McBrien, (New York: HarperCollins, 1995), 421; see a more developed set of criteria in Gula, *Reason Informed by Faith*, 209-215. For analysis of the Curran affair see McCormick, *The Critical Calling*, 111-130; McCormick, *Corrective Vision*, 110-121; also see C. E. Curran, *Faithful Dissent*, (Kansas City, Mo.: Sheed & Ward, 1986); C. E. Curran, *Tensions in Moral Theology*, (Notre Dame: University of Notre Dame Press, 1988), 7-73

Jesus Christ. This normative component of Roman Catholic moral theory must now be elaborated in some detail.

The material that follows may be unfamiliar to some readers. A brief account is now offered in less technical language explaining what I am doing and why, as I investigate the normative perspectives of Roman Catholic moral theory. Four notions are fundamental to all moral analysis: vision, virtue, value and obligation. *Vision* plays a pivotal role and contributes dynamically to moral growth and autonomy on two fronts. First, every individual matures within a community receiving through its stories a picture of what it means to be a person and to act humanly. Second, this vision when appropriated by individuals enables them to integrate the disparate elements that constitute the moral life. Vision situates the moral agent and orients the moral life. Human beings, however, are moral agents and v*irtue*, the second element of the moral life, emphasises the fact that human beings in their activity are unified moral subjects. There is an intimate connection between the thinking and willing of the moral subject and the actual execution of what the person intends in concrete activity. Virtuous living entails a consistent and conscious intention to become the kind of person one's vision calls one to be.[140] The moral life is thus never solely subjective nor merely objective. *Values*, as something good, attract moral agents and make a claim on them such that they experience a sense that something ought to be done or omitted. This sense of being impelled to achieve a particular good is referred to as duty or *obligation.* Values and obligation thus constitute the third and fourth components of the moral life. Goods or values are those things that are sought after by human beings who realise them in society. The natural law tradition of reasoning that has long been used in Catholic moral theology asserts the objective dimension of values and sees in conscience the personal, or subjective, appropriaton of these values into human living. Moral theology eschews all forms of determinism in its analysis of obligation. Human freedom is at the core of human morality: to be free is to be moral! This fundamental characteristic of the moral person and behaviour is the ground of human responsibility.

These four components play an important role in the argument of this thesis. The Christian vision offers a rich and integrating view of the moral life through the stories that tell of God's dealings with people in the Jewish and Christian covenants. Implicit in this vision is a call to live good and holy lives and to prize those values that enable humans to flourish. This dynamic pervades the practical issues of justice and health care that are analysed extensively in this thesis. The exercise of freedom

[140] The same consistent and conscious intention to evil is required for a life of vice.

in responsible and virtuous behaviour is as important in the lives of the elderly and their carers as it is at all stages of life's journey.

I return here to the more technical language and analysis of Roman Catholic moral theology for the rest of this section. Moral theology, in its concern to relate faith to the complex realities of life in the modern world, attempts to answer the question: What sorts of persons ought we to be, and what sorts of actions ought we to perform by virtue of being believers in Christ? A response to this question entails an *ethic of being* and an *ethic of doing.*[141] By analysing human agency or behaviour human beings make sense of themselves as creatures who act *morally*. This requires attention to both character and conduct, to both moral *being* and moral *doing.*[142] Four questions contribute to an understanding of moral agency. First: *What is the object of our striving as moral agents?*, which points to the role of *value*. Second: *What impels us to go after certain goods rather than others?*, which points to the role of *obligation*. Third: *What are we to be as moral persons?*, which points to the role of *virtue*. Fourth: *What gives context or orientation to all the elements of our moral living?*, which points to the role of *vision*. I argue, in what follows, that the experience of values and obligation are common to all human beings and that virtue and vision play a significant role in human behaviour. However, because of the historical and theological resources outlined above, Catholic moral theory offers a richer understanding of all four aspects of the moral life. To substantiate this argument it is now necessary to consider the way value, obligation, virtue and vision are understood in Roman Catholic moral theory.

6.1.3.1 Value

Every day humans discriminate between things, valuing or prizing some things rather than others. To be human is to find some things important and some things not. What is more, not all things are important for the same reason. Some things are cherished as important simply because they are subjectively satisfying. They feel good and are, therefore, liked. Other aspects of life, however, are judged important because of their utility. They are objectively good for the individual. Visits to the dentist, the pursuit of an education, or regular exercise may or may not be fun. But most people consider

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141 Aristotle wrote that "we become just by doing just acts, temperate by doing temperate acts, brave by doing brave acts." *Nicomachean Ethics*, II.i.4-5. The Old Testament book of Sirach said the same thing: "If you pursue justice, you will attain it and we it as a glorious robe. Birds flock with their kind; so truth returns to those who practice it."(Sir.27:8-9)

142 B. C. Birch and L. L. Rasmussen, *Bible and Ethics in the Christian Life*, revised and expanded edition, (Minneapolis: Augsburg, 1989), 40

them somehow important nonetheless.[143] Contemporary language refers to these as *values.* Traditionally they have been designated *goods* or *the good* (Latin, *bona, bonum).* A number of philosophers have given priority to the subjective dimension of value, arguing that what interests a human being deserves to be called a value.[144] An objectivist understanding, on the other hand, sees "value [as] an intrinsic part or aspect of whatever has value; since value is taken to be independent of the observers it is their task to develop the necessary sensitivity for perceiving the values presented to them."[145] Values are properly moral and hence relate directly to the morality of the person (such as justice), or more commonly, to morally relevant effects of human action. In the second sense values are identical with premoral goods (such as knowledge, health, or friendship).[146]

Values in philosophical and theological ethics refer to the moral goods that are to be realised in society. They are articulated in social life as moral norms which are then used to judge both actions and the structures of society itself. They also have a future orientation since they provide standards for judging the kind of society to which we aspire. Value judgments, then, are judgments about which values we want to see realised in society whether that be through our own actions or the actions of other people. The Christian ethic, as a value ethic, highlights and assesses human efforts to realise the social goods that accord with the values held to be important. The conviction here is that the world is unfinished and human beings are themselves "unfinished" agents. In other words, creation is a dynamic rather than a static notion, and humans are co-participants with God in a grand, ongoing venture.[147]

Catholic moral thinking has traditionally explored the unfinished dimension of the world and humanity through its study of natural law. It has been observed that:

> [o]ne asset of the natural law method in ethics is that it situates morality squarely in the context of basic human values and insights, thus enlarging the community of moral discourse to which Catholics can contribute along with persons of other religious and philosophical convictions. Christianity does not provide a 'special' morality to

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143 Cf. T. E. O'Connell, *Principles for a Catholic Morality*, revised edition, (San Francisco: Harper & Row, 1990), 132

144 For example R.B. Perry's thesis: "that which is an object of interest is *eo ipso* invested with value. Any object, whatever it be, acquires value when any interest, whatever it be, is taken in it." quoted by J. E. Smith, "Values and Value Judgment" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 645

145 Smith, "Values...," in *A New Dictionary of Christian Ethics*, 645. An instrumentalist view between these two extremes may be found in the writings of John Dewey (*ibid.*, 646)

146 Cf. O'Connell, *Principles for a Catholic Morality*, 175-178. Current moral theology uses *non-moral, physical, ontic* as equivalents of *premoral*, particularly when applied to evil.

147 Cf. Birch and Rasmussen, *Bible and Ethics in the Christian Life*, 52

> members of the faith community. But does it or should it make a difference when natural law thinking is placed in a religious tradition, viewing humanity as created by and destined for union with God?[148]

A number of Catholic moral theologians have argued that there is no significant difference. Christian authors operate within the general context of Christian commitment and theology, so any simple separation of faith foundations from substantive natural law conclusions is bound to be artificial.[149] Natural law reasoning builds on Paul's insight in his letter to the Romans where he acknowledges that pagans who have no knowledge of God "demonstrate the effect of the Law engraved on their hearts, to which their own conscience bears witness" [150] In this text Paul emphasises that the moral knowledge of good and evil does not require supernatural revelation. Rather it is in each human conscience that moral value is perceived. Vatican II puts it this way:

> Deep within his conscience man discovers a law which he has not laid upon himself but which he must obey . . . For man has in his heart a law inscribed by God. His dignity lies in observing this law and by it he will be judged.[151]

Vatican II expressed a central tenet of natural law thinking, namely that within the consciences of all human beings there are nonconventional, nonarbitrary moral standards which make genuine moral self-criticism possible. This moral knowledge is valid and possible for all human beings.[152]

Five characteristices of natural law reasoning indicate its provenance. First, human beings can discover within themselves an objective moral standard. Second, they are both the subjects who come to this knowledge and, at the same time, are the object of

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[148] L. S. Cahill, "Reason and Faith in Post-Vatican II Catholic Ethics" in *Theological Voices in Medical Ethics*, edited by A. Verhey and S. E. Lammers, (Grand Rapids, Mich.: William B. Eerdmans, 1993), 85

[149] L. S. Cahill, "Theological" Medical Morality? A Response to Joseph Fuchs" in *Catholic Perspectives on Medical Morals. Foundational Issues*, edited by E. D. Pellegrino, J. P. Langan, and J. C. Harvey, (Dordrecht: Kluwer Academic Publishers, 1989), 94. The divine law is the context within which the natural law is to be viewed. Cf. *Dignitatis humanae*, n.3 in Flannery, *Vatican Council II*, 801-802. For Aquinas on the natural law see Mahoney, *The Making of Moral Theology*, 77-83

[150] 2:15

[151] *Gaudium et spes*, n.16 in Flannery, *Vatican Council II*, 916

[152] J. Boyle, "Natural Law" in *The New Dictionary of Theology*, edited by J.A. Komonchak, M. Collins, (Dublin: Gill and Macmillan, 1987), 704. For an understanding of conscience in Roman Catholic moral theology see O'Connell, *Principles for a Catholic Morality*, 161-173; Gula, *Reason Informed by Faith*, 123-135; R. Hodge, *What's Conscience For? Personal Responsibility in Relation to Conscience and Authority*, (Slough: St. Pauls, 1995); J.M. Haas (ed.), *Crisis of Conscience*, (New York: Crossroad, 1996)

the discovery process which arises from reflection on human experience. Third, this discovery process occurs within the human person.[153] Fourth, natural law is objective, that is, it is a *given* which is arrived at through the workings of the human conscience. Fifth, it operates as a standard or a norm but in a manner different to the patterns or regularities of nature. Natural law is both a standard against which human life may be measured and at the same time it is normative, ordering rational activity.[154]

Traditional moral theology grounded natural law norms in the abstract, ahistorical, metaphysical nature of the human person which was judged to be an unchanging reality. More recently natural law theory has taken as its starting point the human person concretely being realised in the various stages and situations of history.[155] This dynamic notion of natural law does not jettison the assumptions just outlined but, rather, integrates them within a more richly textured human dynamic.

6.1.3.2 Obligation

Value, it should be noted, highlights the dimension of the moral life that reflects the *openness* of our humanity to further development. In this value makes community life *meaningful*. Obligation, on the other hand, emphasises the *givenness* of our humanity and the requirements which arise from our common humanity and our life together. In this obligation makes for the *possibility* of community life:

> Most often . . . moral obligation is 'sensed' and 'intuited' rather than overtly stipulated. It arises amidst relationships so much a part of us that we 'know' what is incumbent upon us without asking for formal moral guides. We recognise what a fitting response would be, given the claims of the relationship.[156]

With the teaching of Immanuel Kant a different direction was taken. The post-Enlightenment period gave momentum to a deontological or duty-based ethic. For Kant *duty* is grounded in human reason alone. This establishes a self-sufficient springboard for human action. Human freedom and the autonomy of morality are

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153 This raises the epistemological question for natural law reasoning.

154 Ambiguities are to be found in the writings of Aquinas and contemporary Catholic thinking between *according to nature* (written in nature/physicalist teleology; e.g. sexuality) and *according to (right) reason* (human experience taken in all its complexity and relationships). Cf. Gula, *Reason Informed by Faith*, 238-241

155 Gula, *Reason Informed by Faith*, 244

156 Birch and Rasmussen, *Bible and Ethics in the Christian Life*, 56-57

judged to reside in the fact that nothing beyond the acknowledgement of obligation or duty is necessary for moral motivation to be present.[157]

Freedom in the Christian view, however, is never an absolute or unlimited. It is always circumscribed in each person by a number of givens.[158] Human freedom has always played a central role in Catholic moral thinking. Vatican II proclaimed the excellence of human liberty and enlarged Catholic thinking beyond the confines of post-Reformation dogma through its teaching on religious freedom.[159] Jesus, after all, taught that the truth will set us free.[160] Possession of the Spirit frees the Christian from sin, death and the Law and enables a new kind of life in freedom.[161] Freedom is the relatively limited capacity to decide who we shall be. It is not something that is active only from time to time, such as at the moment of a choice or decision. Freedom is permanently operative. It governs our whole being all the time. Such freedom is not an immediate datum of experience. It cannot be readily identified by testing. Freedom is not simply an instrument for meeting specific needs of choice. It is that fundamental capacity for making a final and irrevocable choice to *be* someone, to be a particular kind of human being. In that sense, freedom is the capacity for the eternal, for God.[162] How, then, does this notion of freedom connect with the every day experience of moral obligation?[163]

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157 Cf. H. T. Engelhardt, "Duty" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 164.

158 On the biological, psychological, social determinants that circumscribe human freedom see L. Monden, *Sin, Liberty and Law*, (New York: Sheed & Ward, 1965), 19-44. On the free will-determinism debate see J. Macquarrie, "Free Will and Determinism" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 237-38. For an outline of the parallel theological debate on original sin and grace, especially the *De auxiliis* controversy, see McBrien, *Catholicism*, I, 158-161

159 *Gaudium et spes*, n.17; *Dignitatis humanae* in Flannery, *Vatican Council II*, 917, 799-812; see also J. L. Hooper, "Dignitatis Humanae" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer, (Collegeville, Minn.: The Liturgical Press, 1994), 284-90

160 Jn.8:31-32

161 Gal.4:21-31;5:13-26; Rom.6:18-22

162 Cf. R. McBrien, *Catholicism*, Vol. 2, (East Malvern, Vic.: Dove Communications, 1980), 955

163 Contemporary moral theology has explored the issue of moral obligation in terms of the question: *Is the basis of our duty to act to be found primarily in human reason or must we find a transcendental justification for the sense of obligation?* Two schools of thought have dominated the discussion. The *autonomous morality* (German: *Autonome Moral*) school focused less on God as the revealer of morality and more on the human being as the discoverer of it, less on the specific morality of Christians and more on the common morality of all people. The second school of thought, that of the *Glaubensethik* or *faith-ethic* approach, has argued that Christian morality is not to be discovered by unaided reason, that its content cannot be identified with philosophical ethics and that its specific character cannot be limited to considerations of context and motivation. Morality must be developed "out of the middle of faith". V. MacNamara, *Faith*

In this century the central role of *responsibility* in Christian ethics has been articulated by the American Protestant theologian, H. Richard Niebuhr.[164] His influence in Christian ethics has been considerable and aspects of his teaching have been adopted by a number of Catholic moralists. They claim that the notion of responsibility has central importance as a normative motif in moral theology since it responds to the basic theological and philosophical accents of contemporary thought.[165] An ethic of responsibility has three elements. The first may be called *response-ability* which designates the *capacity* of a person to respond to God and the neighbour. The second aspect or *accountability* acknowledges that a moral subject is responsible for the actions he or she performs. The third element of responsible and accountable moral behaviour arises from its enduring character or the quality we call *commitment*. Responsible persons conscientiously and consciously commit themselves to a task or form of life and readily accept accountability for the successes and failures that ensue. This aspect pertains directly to the character of the person.[166]

The relational-responsible dimension of the moral life implicit in the notion of responsibility shifts the focus from a preoccupation with obligation and duty to the much richer dynamic of responsibility with its concern for maintaining and developing relationships.[167] The primary context of an ethic of responsibility in the Judaeo-Christian tradition is to be found in the experience of the Sinai covenant. The biblical notion of covenant expresses the ideal of fidelity and intimacy in the divine-human relationship. This dynamic is the touchstone of all other moral relationships. The moral struggle from Sinai to the present has resulted in widening the net of relations a person acknowledges. It challenges humanity to move beyond tribalism, nationalism, racism and sexism. Even our relationship with the non-human

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and Ethics: Recent Roman Catholicism, (Dublin: Gill & Macmillan, 1985), 57. MacNamara provides an excellent survey of both schools (*ibid.*, 37-66)

164 H.R. Niebuhr, *The Responsible Self. An Essay in Christian Moral Philosophy*, (New York: Harper & Row, 1963); cf. P. Ramsey (ed.), *Faith and Ethics. The Theology of H. Richard Niebuhr*, (Gloucester, Mass.: Peter Smith, 1977)

165 C. E. Curran, *Catholic Moral Theology in Dialogue*, (Notre Dame, Ind.: Fides, 1972), 171-172; see also B. Haring, *Free and Faithful in Christ*, Vol. 1, General Moral Theology, (Homebush, N.S.W.: St. Paul, 1978), 82-85. Layman expresses the underlying dynamics of *responsibility* as follows: "A central feature of relationships is the fact that persons place *demands* (expectations, requests, commands) upon each other....Demands can create obligations if relationships are valued, because there can be no worthwhile relationships if we entirely ignore the demands (expectations, requests, etc.) of others." Layman, *The Shape of the Good*, 129

166 Cf. A. R.Jonsen, "Responsibility" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 545-49. See also A.R. Jonsen, *Responsibility in Modern Religious Ethics*, (Washington, D.C.: Corpus Books, 1968)

167 Himes, "The Contribution...," in *Moral Theology: Challenges for the Future*, 53

dimensions of the universe must be given greater weight. In all dimensions of an ethic of responsibility there is recognition of the social nature of the human person. The Christian is related to God, neighbour, the world and self. Failure to give due weight to all these relationships distorts the meaning of the Christian life.[168] The relational-responsible model of Christian morality is realistic, grounded as it is in human moral experience.[169] It locates moral obligation in an inter-personal network based on a theological understanding of covenant.

6.1.3.3 Virtue

For the past decade or more moral philosophers and theologians have given increasing attention to the role of virtue in the moral life.[170] Prior to that moral philosophers had concentrated their attention primarily on concrete human acts which they justified by resorting to rules or consequential considerations. In this scheme of things questions of virtue, character and the nature of human happiness were ignored. In Roman Catholic moral theology the manualists based their analysis on the understanding of virtue in Aristotle and Aquinas. Their preoccupation, however, was with treating the theological and moral virtues as sources of obligation rather than as the dynamic of moral living.[171] Much recent revisionist moral thinking in Catholic ethics has concentrated more on proportionate reason as it applies to particular acts rather than on a study of the virtues which bring Christian vision, sensitivity and motivation to moral reflection. Proponents of a virtue ethic argue it offers a more adequate explanatory framework than utilitarianism or neo-Kantianism

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[168] Cf. C. E. Curran, *Moral Theology: A Continuing Journey*, (Notre Dame: University of Notre Dame Press, 1982), 45; see also C. E. Curran, *Tensions in Moral Theology*, (Notre Dame: University of Notre Dame Press, 1988), 96-97

[169] The Irish moral theologian, Enda McDonagh has reflected systematically on the human experience of obligation. Cf. McDonagh, *Gift and Call*, 17-39

[170] J. W. Crossin, *What Are They Saying About Virtue?*, (New York: Paulist, 1985); T. F. Schindler, *Ethics: The Social Dimension: Individualism and the Catholic Tradition*, (Wilmington, Delaware: Michael Glazier, 1989), 81-128; J. Porter, *The Recovery of Virtue: The Relevance of Aquinas for Christian Ethics*, (Louisville, Kentucky: Westminster/John Knox Press, 1990); J. Porter, "The Unity of the Virtues and the Ambiguity of Goodness", *Journal of Religious Ethics* 21:1 (1993): 137-63; J. Porter, "Virtue" in *The HarperCollins Encyclopedia of Catholicism*, edited by R. P. McBrien, (New York: HarperCollins, 1995), 1316-17.; P. S. Keane, *Christian Ethics and Imagination: A Theological Inquiry*, (New York: Paulist, 1984); Keenan, *Goodness and Rightness*, 92-116; M. Vidal, *Manuale di etica teologica*, Vol. 1, Morale fondamentale, (Assisi: Cittadella Editrice, 1994), 827-887; D. J. Atkinson, D. H. Field, A. F. Holmes and O. O'Donovan, eds., *New Dictionary of Christian Ethics and Pastoral Theology*, (Leicester: Inter-Varsity Press, 1995), 65-70; D. Mongillo, "Virtù" in *Nuovo dizionario di teologia morale*, edited by F. Compagnoni, G. Piana, and S. Privitera, (Milano: Ed. Paoline, 1990), 1450-74.; R. Frattallone, "Virtù" in *Dizionario di bioetica*, edited by S. Leone and S. Privitera, (Acireale: Ed. ISB, 1994), 1039-43; R. Cessario, *The Moral Virtues and Theological Ethics*, (Notre Dame, Ind.: University of Notre Dame Press, 1991).

[171] Gallagher, *Time Past, Time Future*, 56-62

since it provides a more comprehensive picture of moral experience and stands closer to the issues of ordinary life.

Although no taxonomy of virtues and vices has met with agreement discussions of virtue ethics have certain common features: (1) moral evaluation focuses on the agent's character; actions are important because they display the agent's values and commitments; (2) good character produces practical moral judgments based on beliefs, experience and sensitivity more than on (or instead of) rules and principles; (3) a moral psychology gives an account of how virtues and vices develop; (4) a theory of human fulfilment describes the goal towards which virtues lead and/or in which the virtues are components; (5) increasingly, attention is paid to the cultural shaping of virtues and what relation, if any, exists between specific manifestations of virtues and more universal human traits.[172]

Making virtue the goal of morality highlights the fundamental unity between the person and human activity. This unity of self and action points to the unity of the self and the world. Because of who we are, we affect the world in a particular way; and because of what the world becomes, it affects who we are. Hence virtue is not a private matter. To make virtue the goal of morality is to highlight the primary importance of the interaction between the self and its environment, and to call for a certain quality in that interaction. For that reason virtue is seen to be the goal of morality, not as the immediate purpose of personal actions, but as their outcome.[173]

Most proponents of virtue ethics agree that a virtue "is a disposition to act, desire, and feel that involves the exercise of judgment and leads to a recognizable human excellence, an instance of human flourishing."[174] Virtues are not just dispositions to actions. They are determinations of our emotions, passions, desires, and concerns. They are patterns of saliency, attention, perception and judgment."[175] A virtue may be defined as "an enduring quality of character or intellect, through which an individual is enabled to act in praiseworthy ways or to live a morally good life."[176] For Aquinas a virtue is a habit (Latin, *habitus*), a stable quality of the intellect, will, or passions

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172 This list is given in W. C. Spohn, "Notes on Moral Theology: 1991. The Return of Virtue Ethics", *Theological Studies* 53 (1992): 61

173 Cf. Schindler, *Ethics*, 84

174 L. H. Yearley, "Recent Work on Virtue", *Religious Studies Review* 16 (1990): 1 A number of aspects of virtue ethics will not be considered here, e.g. the distinctiveness of Christian teaching on virtue, the *mean* of a virtue, the connection and equality of the virtues. Cf. Cessario, *The Moral Virtues*, 126-150

175 R. C. Roberts, "Virtues and Rules", *Philosophy and Phenomenological Research* 51 (1991): 329

176 Porter, "Virtue" in *The HarperCollins Encyclopedia of Catholicism*, 1316

through which an individual can do what morality demands in a particular instance, and do it in the right way, that is with the appropriate motivation.[177] The word *habit* can be misleading since it suggests that virtue could be acquired and maintained through unreflective good actions that become customary over time. However, there is a long tradition from Aristotle through Aquinas to the present which holds that virtues must be grounded in a rational apprehension of what it means to live a morally good life.[178]

Observation of the lives of good people leads to the consideration of specific actions and promotes efforts to work out rationally coherent accounts of such behaviour. This task, however, differs from purely scientific observation. We deal with actions and reasons precisely as virtuous people. Our moral reasoning is built on the experience of living out and developing the practices or virtues which we have acquired from within particular communities.[179]

For Aristotle ethics is about the qualities of the good society as expressed in the kinds of persons present in the society. The ancient Greeks considered that morality was directed less to the resolution of moral quandaries than to the deliberation of how we should live. Morality is primarily concerned with the sort of persons we should be. This approach emphasises moral formation since society is both the tutor and the living environment of morality. Biblical faith also emphasises the sense of belonging to a people. As a covenantal community believers have an awareness of their vocation to be a people[180]:

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[177] For a more detailed discussion of the passions in Aquinas see G. S. Harak, *Virtuous Passions: The Formation of Christian Character*, (New York: Paulist Press, 1993); W. C. Spohn, "Notes in Moral Theology: 1990. Passions and Principles", *Theological Studies* 52 (1991): 69-87 sketches recent discussion on the interplay of reason and affectivity in moral experience. L.S. Cahill observes that feminists are critical of the scholastic approach to virtue since it derives from a patriarchal model which gives priority to rationality, control and certitude over affectivity, relationality and dialogue. "For Christian feminists, virtue consists not only in the integrity and rectitude of the rational self. It also requires a relational concern for building communities in which all can contribute to mutual fulfillment, communities secured on a base of justice and ascending toward the completion and transformation of love." L. S. Cahill, "Feminism and Christian Ethics: Moral Theology" in *Freeing Theology. The Essentials of Theology in Feminist Perspective*, edited by C. M. LaCugna, (San Francisco: Harper, 1993), 216

[178] Cf. Porter, "Virtue" in *The HarperCollins Encyclopedia of Catholicism*, 1316. It is important to note here that while the cardinal virtues are sufficient to direct their subject to a humanly good way of life, they are not sufficient to bring one to union with God in the Beatific Vision. This requires the theological virtues of faith, hope and charity.

[179] Cf. Keane, *Christian Ethics and Imagination*, 71

[180] Vatican II referred to the church as "the pilgrim people of God", *Lumen gentium,* nn. 48-51 in Flannery, *Vatican Council II*, 407-413. This understanding has had a profoundly transforming influence on Church life and theology.

> To belong to a people of God means *the formation and transformation of personal moral identity in keeping with the faith identity of the community.* This encompasses more than virtue and character formation, but they are indispensible components. [181]

While virtues are *internal*, a matter of character, they are at the same time moral goods internally related to *practices*. They are habits of behavior nurtured in conduct.[182]

6.1.3.4 Vision

Moral vision incorporates a view of the good we hold, a part of which is how we perceive and regard ourselves and others. Vision points to our integrated grasp of the moral realm. On some occasions a catalytic event may alter one's moral vision. More often than not it is the socialised (or internalised) reflection of the communities we move among that shapes our moral vision. This occurs generally over an extended period of time as the individual grows to maturity and passes through the stages of life. Frequently community moral vision which is internalised by the individual is only vaguely appreciated. Nonetheless it is effective in our lives.[183]

Moral vision establishes a reference point for the other elements of the moral life. It sets the terms for what will be included and excluded from our moral purview. It confers status upon what is of greater importance or less and, indeed, what is of no importance at all. Formation of moral character, decision making and human action are permeated by one's moral vision. What comprises good and evil, right and wrong reflects this vision. The most basic moral notions an individual has, namely what is good, right or fitting, make sense or fail to make sense in light of one's particular

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[181] Birch and Rasmussen, *Bible and Ethics in the Christian Life*, 45. Cf. Gal. 5:18.22-23.24.26

[182] Birch and Rasmussen, *Bible and Ethics in the Christian Life*, 46. For a review of recent work on developmental approaches to virtue see Crossin, *What Are They Saying About Virtue?*, 53-104. Alisdair MacIntyre has argued that communally based tradition has developed certain essential practices which we must acquire so as to live a moral life. The acquiring of these practices is virtue and virtue is the heart of our moral growth. MacIntyre, *After Virtue*, 169-209. For an analysis of MacIntyre's contribution see W. C. Spohn, "Notes on Moral Theology: 1986. Virtue and American Culture", *Theological Studies* 48 (1987): 123-130

[183] Birch and Rasmussen, *Bible and Ethics in the Christian Life*, 59-60. Shifts in moral vision occur at the community and individual levels. The Church's slowly evolving awareness of the evil of slavery is a typical example. Another is the current shift from an anthropocentric to a biocentric ethic which results in expanding our sense of obligation, value and virtue to include all life, not only human life. Cf. H. E. Daly and J. B. Cobb, *For the Common Good. Redirecting the Economy toward Community, the Environment, and a Sustainable Future*, (Boston: Beacon Press, 1989), 376-400; S. G. Post, "The Emergence of Species Impartiality: A Medical Critique of Biocentrism" in *Inquiries in Bioethics*, (Washington, D.C.: Georgetown University Press, 1993), 161-75

moral vision. Moral vision incorporates, therefore, a sense of the total environment within which the moral life is lived.[184]

Vision in the moral life involves more than logic. Moral vision makes possible a creative, integrating, imaginative grasp of the meaning of life. In this context it is imagination that provides the means by which we draw together the concrete and the universal elements of human experience. With imagination we let go of any inadequately pre-conceived notions of how the abstract and the concrete relate to one another. We suspend judgment about how to unite the concrete and the abstract. We let the two sides of our knowing play with one another. By allowing this interplay between the two aspects of our knowing, we get a much deeper chance to look at what we know, to form a vision of it. "With this deeper, imagining vision of reality we are able to make a more appropriate connection between conversion and abstraction."[185] It is for this reason that recent Roman Catholic moral theology has given a greater role to imagination and the other modalities of human knowing.

Human vision is considerably enriched by the way narrative or story function in human lives and by the way they influence the traditions of particular communities.[186] In order to properly appreciate moral behaviour it is important to attend to the images shaping the imagination. Stories shape these images and are prior in time to any moral rules articulated within the community. In fact, humans live more by stories than by rules. Individuals must first learn, therefore, *how* to see. Only then do moral rules come into play. To a great extent one's vision is not something constructed by the individual but is inherited from social worlds within which the individual lives. Vision is thus fundamentally a community achievement.[187]

For these reasons human behaviour is a function not so much of the moral propositions we hold to be true as it is of the imagination which holds the images before our minds giving us a *picture* of the world. In forming one's conscience to make moral judgments we must be critically alert to the images at play in the

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[184] Birch and Rasmussen, *Bible and Ethics in the Christian Life*, 62

[185] Keane, *Christian Ethics and Imagination*, 81.

[186] Keane, *Christian Ethics and Imagination*, 66. "MacIntyre, like Daniel Callahan and Edward Shils, also lays great stress on the importance of tradition as a source of objective moral wisdom. Tradition heightens narrative's importance because narrative serves to bear tradition to us."(*ibid.*, 67). While the role of the comic and the tragic have been very influential in human history through literature and the arts the way in which an appreciation of beauty develops the moral vision has received less attention in moral reflection. Cf. B. Haring, *Free and Faithful in Christ*, Vol. 2, The Truth will set you free, (Homebush: St. Paul, 1979), 102-152

[187] Cf. Gula, *Reason Informed by Faith*, 142

imagination. Christian morality assumes that the stories and images integral to the Christian community and tradition sketch an understanding of goodness in the moral life. They, in fact, provide truthful ways of seeing the world. How decisive the Christian stories actually are will depend on how deeply each person appropriates them in becoming a Christian. Incorporating these stories into one's way of seeing, feeling, thinking, judging and acting helps the believer to engage the world as a person formed by Christian faith.[188]

When a person *gets the picture* through the imaginative process he or she comes to an image which integrates diverse beliefs and experiences. This enables the individual to understand what is going on and what is required to act appropriately in the particular context. When religious beliefs are part of the imaginative process, they enter into the content of what we experience and contribute toward connecting the many dimensions of experience with the values entailed in those beliefs. This gives a distinctively religious *picture* of the world and a way of responding to it. Since we are guided and formed by the images which give us a picture of the world, the imagination sets both the direction and limits to moral behavior. Imagination informs what we think, what we see, the way we feel, our readiness to act, and the direction of our actions. It gives a definiteness to our characters in such a way that when our master images change we, too, are significantly changed. The master images that dominate an individual or a community's imagination offer a concrete pointer as to who the individual is or what sort of community is present. They help us to organise our lives and influence our moral arguments, choices and actions.[189] Imaginative insight and traditional stories in the Christian community are, therefore, powerful influences in constructing the Christian moral vision.

6.1.3.5 Concluding Comments

The above analysis of the role of value, obligation, virtue and vision in Roman Catholic moral reflection has indicated the variety of ways that moral claims apply to the individual lives of believers and to the wider Catholic community. This state of affairs is not radically discontinuous with the normative character of all human morality. Rather, I have argued that Roman Catholic moral theory contributes three significant elements to moral analysis and to the demands of human morality. These may be designated by the notions of community, comprehensiveness and integration. The radical importance of a community's ethos has been illustrated by the way stories and imaginative understanding have contributed to the basic picture Christians

[188] Gula, *Reason Informed by Faith*, 146

[189] Cf. Gula, *Reason Informed by Faith*, 72

have of themselves as human beings. Virtuous persons are living exemplars, one might even say living "pictures", of the type of person the Christian message calls humans to be. This picture is not selective but, rather, comprehensive in its scope. The study of value has indicated the concern within Roman Catholic moral theory for both the subjective and objective elements of the moral life. This is shown particularly in the place it gives to conscience and natural law. The comprehensive character of morality is also to be found in the notions of freedom and responsibility that are central to Catholic moral thinking. Throughout this study the integrating power of vision for the moral life has been clearly obvious. This is concretely expressed in the seamless connection between the person and behaviour articulated in virtue theory.

6.2 CATHOLIC MEDICAL ETHICS

In the previous section I have argued that Roman Catholic moral theory has particular features that are long standing (historical perspective), comprehensive (theological perspective) and life-enhancing (normative perspective). These offer a more adequate approach to the central issues of this thesis than has been proposed by liberal understandings of the state and justice. In this section it is asserted that Roman Catholic medical ethics displays these same three features as part of the discipline of moral theology. Through three lenses ground from historical, theological and normative perspectives it is possible to articulate the substantive elements of Roman Catholic medical ethics that directly shape the contribution of Roman Catholic moral theory to the issue of just health care for aged Australians.

6.2.1 Historical Background

The relationship of medicine and theology has a long history within the Christian community. That relationship has been shaped by the forms moral theology has taken. Manuals of moral theology were the dominant genre in Roman Catholic moral theology from the mid-sixteenth century to recent memory.[190] Medico-moral questions were considered within the general framework of the manuals which analysed the moral life using the schema of the decalogue or the virtues.[191] Four

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190 For a general historical survey see C. E. Curran, *Issues in Sexual and Medical Ethics*, (Notre Dame, Ind.: University of Notre Dame Press, 1978), 55-70; C. E. Curran, *Transition and Tradition in Moral Theology*, (Notre Dame: University of Notre Dame Press, 1979), 173-206

191 Jesuit moralists mainly used the decalogue, Dominican thinkers adopted a virtue framework.

particular sections generally considered medical issues in the manuals of moral theology: the fifth commandment on killing, the sixth and ninth commandments dealing with sexual behaviour, the sacrament of marriage and the section dealing with duties of various states of life.[192] Throughout this historical period the principle for selecting topics for medical moral analysis underwent a development: from what penitents confessed, to what was proper to particular commandments, virtues and sacraments, finally to issues of medical practice.

The Church has always recognised the importance of healing both of body and soul and has long been interested in the issues that arise from the interaction of these two dimensions of healing. The Enlightenment, however, ruptured the link between these two areas of healing. To bridge this gap a field of study known as *Pastoral Medicine* developed. The literature had a two fold audience.[193] It spoke to priests and theologians about what they might need to know of medicine, especially about hygiene and first aid, so that country pastors might be of some use to their parishioners. It spoke also to doctors giving them necessary knowledge about religion, spirituality and morality.[194]

Medical ethics as a separate discipline within moral theology developed from the literature of pastoral medicine and as a result of contacts with the medical ethics of nineteenth century medical associations. Initially strong resistance was shown to the use of the term *medical ethics* for the developing discipline within Catholic moral theory. This was primarily due to a restrictive use of the term in the medical fraternity to issues of medical etiquette and professional codes of conduct which were designed for professional self-interest rather than for better clinical practice.[195]

A third factor contributing to the development of twentieth century Catholic medical ethics is to be found in the rapid proliferation of theological periodicals during the last third of the nineteenth century.[196] This enabled moral theologians to respond

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192 D. F. Kelly, *The Emergence of Roman Catholic Medical Ethics in North America: An Historical-Methodological-Bibliographical Study*, (New York: Edwin Mellen Press, 1979), 28-40

193 Two influential texts of pastoral medicine: Capellmann's *Medicina pastoralis* (translated into English in 1878 for an American audience) and Antonelli's text of the same name published during the period 1920-1932. For detailed study of these authors see Kelly, *The Emergence of Roman Catholic Medical Ethics in North America*, 69-81

194 D. F. Kelly, *Critical Care Ethics. Treatment Decisions in American Hospitals*, (Kansas City, Mo.: Sheed & Ward, 1991), 90.

195 Kelly, *Critical Care Ethics*, 75-78

196 For an exhaustive list of periodical titles see E. Hocedez, *Histoire de la théologie au XIXe siècle*, Vol. 3, (Paris: Desclee de Brouwer, 1952), 330 and A. Vermeersch, "Soixante ans de théologie morale", *Nouvelle Revue Théologique* 56 (1929): 866-67. Furthermore Vermeersch asserts that

more quickly to newly developing problems.[197] Their style of response up until the Second World War was influenced by the neo-scholastic revival instituted by Pope Leo XIII, by renewed studies in natural law[198], by more frequent teaching on moral issues by successive popes and by the Roman congregations[199] and finally by the Code of Canon Law (1917).[200]

Roman Catholic medical ethics evolved primarily as moral investigation into the actual practice of health care professionals. Practitioners of this medical ethics saw themselves as applying "moral principles to the daily professional activity of medical personnel, in order that they, as well as the clergy and laity who might be concerned as moral guide, chaplain, or patient, would know and carry out correct moral procedure."[201] Characteristic of Catholic medical ethics, especially in the U.S.A., was the way it emphasised the place of health in modern medicine and the role of direct physical and surgical interventions in therapy.

David Kelly, in his very detailed study, has traced the evolution of Catholic medical ethics in three stages: 1897-1940, 1940-1960 and 1960 to the present:

> Briefly stated, North American Roman Catholic medical ethics applied theological principles (principles such as God's dominion over human life and the redemptive meaning of suffering in Christ) according to two general approaches or modalities of application: physicalism and ecclesiastical positivism. These general modalities became the determining processes for solving ethical questions of medicine.[202]

He has argued that during the first period a *physicalist* methodology dominated Catholic medico-moral reflection. This approach arrived at ethical judgments on the basis of physical criteria and in a quasi-scientific way. It sought to give the moralist the capacity to reach conclusions applicable in every single instance where the physical action (such as a surgical operation) was the same. Ecclesiastical positivism

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"les travaux plus originaux et plus approfondis reçoivent l'hospitalité dans les periodiques."(*ibid.*, 866)

197 Current Catholic periodicals attest to the continuing influence of this format in medical ethical discussion, e.g. *Artz und Christ* (Germany), *Cahiers Laennec* (France), *The Catholic Medical Quarterly* (U.K.) and *The Linacre Quarterly* (U.S.)

198 M. B. Crowe, *The Changing Profile of the Natural Law*, (The Hague: M. Nijhoff, 1977), 246-290

199 For a list of statements see G. Kelly, *Medico-Moral Problems*, (St. Louis: The Catholic Hospital Association, 1961), 336-339

200 Cf. D. O'Callaghan, "A Hundred Years of Moral Theology", *Irish Ecclesiastical Review* 102 (1964): 236-41; R. Metz, "Canon Law, History of. 7. The Code of Canon Law to the Present" in *New Catholic Encyclopedia*, Vol.3, (New York: McGraw-Hill, 1967), 49-50

201 Kelly, *The Emergence of Roman Catholic Medical Ethics in North America*, 221

202 Kelly, *The Emergence of Roman Catholic Medical Ethics in North America*, 108

dominated the 1940-1960 period in medical ethics.[203] This coincided with the leading role played by the papal magisterium especially during the pontificate of Pius XII.[204] Kelly described the positivism used by the Church during this period as "a specific kind of theological voluntarism or metaethical supernatural absolutism". An action was judged to be right or wrong depending on whether it was acceptable or not to the magisterium. While this approach was not adopted theoretically it did operate in practice.[205]

The third phase has been shaped by an increasing emphasis on the human person. Contemporary personalism emphasises the whole person (as against the individual act) and the complex multi-dimensional human situation (as against direct physical consequences). This, according to Kelly, has opened up the theological themes that underpin medical ethical reflection, namely God's dominion over human life and the redemptive meaning of suffering. These point to two dimensions of a creature's relationship to the Creator. They are no longer subordinate to natural law reasoning and arguments from authority but

> act as hermeneutic themes in the context of the central question of Christian anthropology, the question which is central to all of medical ethics, which, if a neologism is warranted, could be called the 'biosignificance question': what is the meaning of human life?[206]

Kelly's conclusion is that Catholic medical ethics has moved away from a strict rule-based method and has focused on human goals and the human context.[207] While this has occurred in Catholic medical ethics, religiously based medical ethics have increasingly been marginalised in the Anglo-American scene by the vigorous growth of secular bioethics. This state of affairs has been considered earlier in chapter 3. It is sufficient here simply to note a perceptive critique of contemporary U.S. bioethics made by Richard McCormick S.J., a leading American moral theologian and bioethicist. His analysis offers an appropriate bridge to a consideration of the theological dimensions of Catholic medical ethics which follow. McCormick claims

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203 Kelly, *The Emergence of Roman Catholic Medical Ethics in North America*, 231-232. For a survey of the literature see pp.311-401

204 Pius XII taught on a range of issues usually by means of addresses to professional gatherings, e.g. on artificial insemination (1949), on marriage and childbirth (1951, 1956), on medical research and experimentation (1952), on mutilation (1953), on fertility and sterility (1956), on pain relief (1957). Cf. Kelly, *Medico-Moral Problems*, 338-339

205 Two outstanding examples are Kelly, *Medico-Moral Problems* and T. J. O'Donnell, *Morals in Medicine*, (Westminster: Newman Press, 1956)

206 Kelly, *The Emergence of Roman Catholic Medical Ethics in North America*, 437

207 Kelly, *Critical Care Ethics*, 97

there is a malaise in contemporary bioethics.[208] He uses Catholic hospitals as the starting point in his argument. Even in these institutions, which might be expected to reflect a particular Catholic ethos, other values are clearly influential. Not least among them are elements of contemporary management rhetoric exemplified by the four characteristices of a healthy organisation proposed by Peters and Waterman in their book, *In Search of Excellence*: (1) shared values (or culture) are to be found throughout the company; (2) these values are crystal clear; (3) they are communicated by legends and stories; (4) these values give meaning, motivation and inspiration to the work of individuals within the organisation. In the light of this McCormick has observed that

> [c]ulture is essential to the flourishing of institutions, whether they be Catholic hospitals or business corporations. When the culture is dysfunctional or absent, we usually see a company in disarray. We see a Catholic hospital questioning its identity. More to the point, we see a situation where 'people's only security comes from where they live on the organizational chart'. We see people who have jobs, not great causes.[209]

The implications of this for Catholic health care systems will be explored later. Paralleling the malaise within bioethics is a similar state of affairs occurring in contemporary medicine and health care delivery. McCormick fears that the medical profession is itself threatened and perhaps even already severely undermined by certain forces in American culture. He designates five of these.[210] First, *depersonalisation*: increasing use of technology, concern with costs and cost containment, and the multiplication of public entities in health care are impersonal forces which preprogram treatment and tend to depersonalise medical care that ought be tailor-made to the individual, to his or her condition and values. Second, *secularisation*: this occurs when the profession is divorced from the values that make it a human service. The culture of compassion and care central to the doctor-patient relationship is replaced by a business ethos which forces the doctor to make secularised judgments.[211] Third, the *emergence of public morality*: when groups with

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[208] R. A. McCormick, "Beyond Principlism Is Not Enough. A Theologian Reflects on the Real Challenge for U.S. Biomedical Ethics" in *A Matter of Principles? Ferment in U.S. Bioethics*, edited by E. R. DuBose, R. P. Hamel, and L. J. O'Connell, (Valley Forge, Pa.: Trinity Press International, 1994), 345

[209] McCormick, "Beyond Principlism...," in *A Matter of Principles?*, 347-348

[210] McCormick, "Beyond Principlism...," in *A Matter of Principles?*, 350-356

[211] James Drane, from the perspective of virtue ethics, proposes *friendship* as a key element in the doctor-patient relationship. "To talk about medical friendship is to reintroduce the concept of a bond that is threatened in contemporary medicine. The technical mentality today, like the magical mentality in prehistorical medicine, does away with a doctor-patient relationship. Both mentalities physically separate doctor and patient by making diagnosis and therapy depend either on a machine or a formula; a piece of technology or a ritual. In neither case is a personal

concerns other than those of the individual patient mediate health care (or research) the individual is inserted into the value perspectives of a wider society. The latter begins to shape the particular care offered. American obsession with technology, efficiency and comfort illustrate this point. Fourth, *a market-driven health care system*: increasingly doctors are being pressured to exercise the role of fiscal gatekeepers. Fifth, the *crisis in nursing*, particularly the shortage of nurses, is having repercussions at all levels of health care.

Cumulatively these five forces have undermined both medicine as a profession and health care in general. Furthermore, the momentum of contemporary culture is such that the ethos of Catholic health care is likewise being eroded at the institutional level. This is occurring despite the strong historical and theological concern with healing and care of the sick within the Catholic community. Medicine, bioethical reflection and the Catholic identity in health care, if they are to maintain their roles in contemporary society, must vigorously engage the destructive forces at work in contemporary culture. McCormick's concern offers a salutary warning as to the importance and urgency of the issues at stake.

6.2.2 Theological Dimensions

In 6.1.2.1 attention was given to the essential link that Roman Catholic moral theory makes between faith and morality. Within the Catholic community this nexus is resourced through the teaching of scripture, the accumulated wisdom of tradition and the authoritative directives of the magisterium. Against this background the specifically theological perspectives of Roman Catholic medical ethics may now be developed. It is argued in this section that a theologically grounded medical ethics gives priority to the way human beings are present to one another and to the dynamic that shapes the encounter. These two features have particular implications for the way in which health care should be delivered to aging persons.

6.2.2.1 Embodied Presence

Fundamental to the Christian tradition is the belief that God's presence continues to be with us in the constant activity of the Spirit and in the life of grace. The God of

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relationship between healer and patient necessary. Consequently, the whole idea of a character trait or virtue which makes that personal relationship possible also slips from consideration." J. Drane, "Character and the Moral Life: A Virtue Approach to Biomedical Ethics" in *A Matter of Principles? Ferment in U.S. Bioethics*, edited by E. R. DuBose, R. P. Hamel, and L. J. O'Connell, (Valley Forge, Pa.: Trinity Press International, 1994), 305-306; cf. J. Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, (Kansas City: Sheed & Ward, 1988)

Moses and the God of Jesus Christ continues to be involved in human life, transforming human existence. In the relationship that is grace God gives of himself and human beings respond:

> The encounter, the dialogue, the relationship that is grace takes place in our everyday lives. Because of the gift of grace, attentive and receptive persons are able to recognize the presence and the movement of the divine in human experience. All life, therefore, is 'holy ground'; all experience has the potential to reveal.[212]

Fundamental to Roman Catholic theology in general, and medical ethics in particular, is emphasis on *mediation*. God ordinarily works through secondary causes, mediately. Thus, God works in this world through the visible community of believers, the Church.[213] Each person is called to conversion, a process that continues throughout life.[214] This entails a turning back to a merciful God, to an ever deeper understanding of who God is and a greater readiness to walk as a disciple of the Lord.[215] For this reason the provision of health care within the context of faith always calls to conversion.[216] This new self-understanding in faith expresses itself in good works that serve the needs of others. In his or her physical presence the believer mediates to others the gift of grace received in the Spirit. This is especially so where the needy and vulnerable are involved. Christ's presence in people and in the world is *sacramental*. In its widest sense the concept of sacrament applies to "any finite reality through which the divine is perceived to be disclosed and communicated, and through which our human response to the divine assumes some measure of shape, form and structure."[217] Taken in the more specific sense sacrament applies to "those finite realities through which God is communicated to the Church and through which the Church responds to God's self-communication."[218] The Church as the sign and instrument of the kingdom of God understands itself to be the fundamental sacrament.[219] The seven sacraments, while acts of God, are immediately acts of the

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212 J. Casey, *Food for the Journey. Theological Foundations of the Catholic Healthcare Ministry*, (St. Louis, Mo.: The Catholic Health Association of the U.S., 1991), 10

213 J. C. Harvey, "A Brief History of Medical Ethics from the Roman Catholic Perspective: Comments on Essays of Fuchs, Demmer, Cahill and Hellwig" in *Catholic Perspectives on Medical Morals. Foundational Issues*, edited by E. D. Pellegrino, J. P. Langan, and J. C. Harvey, (Dordrecht: Kluwer Academic Publishers, 1989), 131-132

214 "Repent and believe" (Mk.1:14-15; Mt.4:12-17)

215 Cf. the parable of the prodigal Father (Lk.15:11-24)

216 Casey, *Food for the Journey*, 11

217 McBrien, *Catholicism*, Vol. 2, 732

218 McBrien, *Catholicism*, Vol. 2, 732; *Catechism of the Catholic Church*, n.1131

219 It is the "sacrament of universal salvation", *Lumen gentium*, n.48 in Flannery, *Vatican Council II*, 407-409; *Catechism of the Catholic Church*, n.1118

Church.[220] "They are moments when the Church becomes Church, manifesting itself as Church to itself and to others."[221]

Vatican II sought to initiate a positive dialogue between religious belief and contemporary society. The Council affirmed that religious faith casts a fresh light on all things. They are perceived in the context of God's call to all humanity. The human mind is prompted to find fully human solutions to all of life's problems.[222] In doing this the Council

> was officially ushering in for the Church a new programme of Christian humanism, which would take human reality with all respect and seriousness and explore its strengths and its weaknesses in the strong belief that God, the originator of all worldly and human realities, wishes them to find their own fulfilment.[223]

Christian humanism, then, starts from the conviction that the human is part of the gospel, that God's grace is secretly present in the whole of creation and that God's concern is centred on the human person in his or her dignity, mystery and destiny.[224] Such belief finds its expression Vatican II proclaims the obligation encumbent on all Christians "to work with all men in constructing a more human world."[225]

Attention to the human context requires that Catholic medical ethics be conscious of the cultural assumptions, trends, unexamined attitudes and biases embedded in particular human communities.[226] Reference has already been made to McCormick's concern about the wider cultural influences in U.S. society that are considered destructive of contemporary medicine, bioethical reflection and the identity of

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220 Baptism, eucharist, confirmation, penance, anointing of the sick, marriage and holy orders; cf. *Catechism of the Catholic Church*, nn.1210-1666

221 McBrien, *Catholicism*, Vol. 2, 733

222 *Gaudium et spes*, n.11 in Flannery, *Vatican Council II*, 912

223 J. Mahoney, *Bio-ethics and Belief. Religion and Medicine in Dialogue*, (London: Sheed & Ward, 1984), 109

224 The agenda of Christian humanism is to "walk side by side with purely secular and other forms of humanism, as setting out from a shared starting point, but it will also be forever encouraging other humanisms to lengthen their stride and to take those extra steps towards the full perfection of which man is capable, towards the form of human society which alone can do full justice to man who is also the image of God." Mahoney, *Bio-ethics and Belief*, 110. An understanding of Christian humanism is proposed here for it is fundamental to (1) charting Catholic contributions in all areas of contemporary bioethics and the public policy issues connected, and (2) rejecting the approach proposed by Engelhardt for a bioethics based on secular humanist foundations. Cf. H. T. Engelhardt, *Bioethics and Secular Humanism: The Search for a Common Morality*, (London: S.C.M., 1991)

225 *Gaudium et spes*, n.57 in Flannery, *Vatican Council II*, 961-962

226 Karl Rahner referred to such assumptions as *global prescientific convictions*. Richard McCormick sees them as *value variables* in contemporary bioethics. Cf. R. A. McCormick, "Hidden Persuaders: Value Variables in Bioethics" in *Corrective Vision*, 165-75

Catholic health care. He has clearly identified the ways these destructive influences are present as assumptions permeating contemporary bioethical reflection: the denial of mortality, a eugenic mentality, the conviction that good health care equals efficient rescue medicine, the absolutisation of autonomy, dignity understood as independence, the secularisation of medicine, an interventionist mentality, confusion of the legal and the moral arenas, morality viewed as purely personal, a functional assessment of the person. These attitudes are often intertwined and must be attended to as Catholic medical-moral reflection, one mode of Christian humanism, enters into dialogue with other participants in public discourse and policy development.

In its *Declaration on Euthanasia* the Congregation for the Doctrine of the Faith made reference to "Christ, who through his life, death and resurrection, has given a new meaning to existence."[227] If this is the case, as Christians believe, then this will have important implications for bioethical reflection. The biblical story which shapes the Christian understanding of the world contributes the following key elements for a *theologically* based medical ethics:

- God is the author and preserver of life. We are made in his image.
- Life is a gift, a trust. It has great worth because of the value God places in it.
- God places great value in it because he is also the end, purpose of life.
- While God has dealt with us in many ways, Jesus Christ is his supreme epiphany.
- In Jesus' life, death and resurrection we have been totally transformed into *new creatures*, into a community of the transformed. Sin and death have met their victor.
- The ultimate significance of our lives consists in developing this new life.
- The Spirit is given to us to guide and inspire us on this journey.
- The ultimate destiny of our combined journeys is the coming of the Kingdom, the return of the glorified Christ to claim the redeemed world.
- Thus we are offered in and through Jesus Christ eternal life. Just as Jesus has overcome death (and now lives), so will we who cling to him, place our faith and hope in him, and take him as our law and model.

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[227] Congregation for the Doctrine of the Faith, "Declaration on Euthanasia", *Origins* 10 (1980): 155

- This good news, this covenant with us has been entrusted to a people, a people to be nourished and instructed by shepherds.
- This people should continuously remember and thereby make present Christ in his death and resurrection at the eucharistic meal.
- The chief and central manifestation of this new life in Christ is love for each other, especially for the poor, the marginal, sinners. These were Jesus' constant companions.[228]

The new meaning that comes from this new existence in Christ gives direction to the way Christians are to work for a more human world. Particularly by concern for the sick do Christians and the Church seek to embody Christ's message of salvation.

The gospel accounts of Jesus' ministry draw special attention to his acts of healing: He cleansed a man with leprosy[229]; he gave sight to two people who were blind[230]; he enabled one who was mute to speak[231]; he cured a woman who was hemorrhaging[232]; and he brought a young girl back to life[233]. Indeed, the gospels offer many examples of how the Lord cured every kind of ailment and disease.[234] In the account of Matthew, Jesus' mission fulfilled the prophecy of Isaiah: "He took away our infirmities and bore our diseases".[235]

Jesus' healing mission went further than caring only for physical affliction. He touched people at the deepest level of their existence; he sought their physical, mental and spiritual healing.[236] He "came so that they might have life and have it more abundantly".[237] The mystery of Christ casts light on every facet of Catholic health care: Christian love is to be its animating principle; healing and compassion are viewed as a continuation of Christ's mission; suffering is a call to participate in

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[228] McCormick, "Hidden Persuaders...," in *Corrective Vision*, 138-139; See also McBrien, *Catholicism*, Vol. 1, 135-137 where the documents of the official teaching of the church on the meaning and context of human existence are listed

[229] Mt.8:1-4; Mk.1:40-42

[230] Mt.20:29-34; Mk.10:46-52

[231] Lk.11:14

[232] Mt.9:20-22; Mk.5:25-34

[233] Mt.9:18, 23-25; Mk.5:35-42

[234] Mt.9:35

[235] Mt.8:17; cf. Is.53:4

[236] Jn.6:35; 11:25-27

[237] Jn.10:10

the redemptive power of Christ's passion, death and resurrection; death, transformed by the resurrection, offers an opportunity for ultimate communion with Christ.[238]

In faithful imitation of Jesus Christ the Church has served the sick, suffering and dying in various ways throughout history. Commencing with the deacons appointed to care for the needs of the poor in the infant Christian community individuals and groups within the Christian community have provided shelter for the traveller, infirmaries for the sick and homes for children, adults and elderly people.[239] Throughout the Church's history members of religious communities have modelled their efforts on the gospel parable of the Good Samaritan offering neighbourliness to those in need.[240]

6.2.2.2 *The Theological Dynamic: Faith, Hope and Charity*

Medical ethics is theological if it proceeds from faith.[241] This faith is ultimately not the assertion of the truth of certain faith-propositions, but an act, in the depth of the person, of giving and entrusting oneself to the God who reveals and imparts himself to us. A medical ethic cannot be developed out of faith understood in this way. However, human and philosophical attempts to understand medical problems are ultimately derived from *faith* and are propelled by faith:

> It is in this sense that the medical ethics of the Catholic who holds on to his faith in his moral reflection is a Catholic ethics, even though it works with the intellectual tools of the philosopher. This, however, is only a partial truth, because living faith also signifies an interior disposition to seek the truth, the whole truth, and nothing but the truth, and such a disposition, present in the basis of faith, has primary significance for the seeking and discovering of medical moral norms.[242]

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[238] Cf. U.S. Bishops, "Ethical and Religious Directives for Catholic Health Care Services", *Origins* 24:27 (1994): 451

[239] Acts 6:1-2; Cf. E. Nasalli-Rocca, "Hospitals, History of. 1. The Christian Hospital to 1500" and A. B. McPadden, "Hospitals, History of. 2. 1500 to Present" in *New Catholic Encyclopedia*, Vol. 7, (New York: McGraw-Hill, 1967), 159-63, 163-66; T. S. Miller, "Hospital. I. Medieval and Renaissance History" in *Encyclopedia of Bioethics*, edited by W. T. Reich, Vol. 2, (New York: Simon & Schuster Macmillan, 1995), 1160-63

[240] Lk.10:25-37. A. Jonsen argues that "[t]his 'Samaritanian principle' deserves to stand beside the 'Hippocratic principle' of competence in its importance for medicine in our culture...[T]wo broad ethical traditions flow through Western medicine: competence and compassion. The ideal physician has always been seen as the bearer of both virtues, and departures from either have been deplored." Jonsen, *The New Medicine…*, 39-40

[241] *Catechism of the Catholic Church*, nn.142-165, 1814-1816, 2087-2089

[242] J. Fuchs, ""Catholic" Medical Moral Theology?" in *Catholic Perspectives on Medical Morals. Foundational Issues*, edited by E. D. Pellegrino, J. P. Langan, and J. C. Harvey, (Dordrecht: Kluwer Academic Publishers, 1989), 86

These two dimensions of faith are raised here for two reasons. First, there exists a temptation, at least in the Roman Catholic tradition, to treat theology primarily as reflection on credal statements. This approach brings with it a certain *tidiness* both in understanding and application. Consequent on this emphasis is a preoccupation with the content of norms in medical ethics and with the policies necessary for implementing Catholic teaching in Catholic health care facilities. Second, and more importantly, an awareness of faith as *commitment* requires that the *messiness* of personal faith and moral decision-making be considered in the delivery of health and medical care to people. The lived service of others by committed believers thus becomes an authentic *locus* for doing the truth.[243]

Furthermore, Christian faith exercises a protective function in medical ethical reflection.[244] Natural law thinking identifies basic inclinations in human beings, inclinations to goods which define human well being and ensure human flourishing. As technically competent people we frequently view nature as something over which we exercise power, manipulating it to our ends. A faith perspective, on the other hand, starts from the insight that nature is God's creation, to be respected and heeded. Our role is as stewards. When technology creates problems the common response today is to undertake further research to remove the condition that prevails. It can follow from this that certain categories of people are treated functionally and as problems. The maladapted (such as the defective of mind or body) are put aside and even, at times, removed (as proposed by supporters of voluntary euthanasia). It is here that the protective role of faith in action can be seen. The believer is consciousness that

> the single, dominating, all pervasive vitality in Jesus was the God-relationship. The human goods that define our flourishing (life and health, mating and raising children, knowledge and friendship, enjoyment of the arts) while desirable and attractive in themselves, are *subordinate* to this structural God-relationship. Yet it is the characteristic of the redeemed but still messy human condition to make idols, to pursue these basic goods *as ends in themselves*. This is the radical theological meaning of secularization: the loss of the context which relativizes and subordinates these basic goods and prevents our divinizing them.[245]

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[243] McCormick is correct when he says "'reason informed by faith' is shorthand for saying that the reasoner (the human person) has been transformed and that this transformation will have a cognitive dimension through its invasion of consciousness...that the more profound the faith, the greater and more explicit will be the Christian consciousness - which is a way of saying that how faith (and theology) affects ethics can be seen best of all in the saints." R. A. McCormick, "Theology and Bioethics" in *Corrective Vision*, 141

[244] Cf. McCormick, "Theology and Bioethics" in *Corrective Vision*, 141-143

[245] McCormick, "Theology and Bioethics" in *Corrective Vision*, 143

The normative character of the God-relationship known in faith stands as a protective barrier against any change of focus where basic goods become ends in themselves. For the religious tradition this is idolatry and challenges the believer to action. This results in a dialectic where experience is submitted to the bar of belief and belief to the bar of experience. Today this is "a requirement of every believer, on pain of leaving his experience unanchored and his belief unsubstantiated."[246]

The Christian "is not a person who grasps for something tangible so that he can enjoy it until death comes, nor is he a person who takes the darkness of the world so seriously that he can no longer venture to believe in the eternal light beyond it."[247] Christian living has both a past and future orientation. Central to Christian faith is the conviction that we will rise from the dead as Jesus did. St. Paul puts it clearly: "if Christ has not been raised then our preaching is useless and your believing it is useless."[248] Two important consequences flow from this. First, the belief in human destiny beyond the grave becomes an ultimate statement of the dignity and worth of each and every human person. This awareness has immediate and direct consequences for every form of health care. Second, if the hope of resurrection reminds us that there is more to life than what we experience here on earth, then the power of the resurrection can make us more ready to face up to the fact of death and more ready to accept that the time for death may have come.[249]

Christian hope not only gives focus and immediacy to every moment. It also (1) grounds an attitude of optimism at every stage of life; (2) generates a sense of responsibility for improving the present situation, such as the development and use of pain control; (3) removes isolation and fear frequently associated with illness and suffering and ensures the expression of solidarity with the most vulnerable and needy in our society.

The faith-full Christian reflects in his or her dispositions the very shape of that faith - the self-gift we call *charity* (love of God in others, charitable action).[250] The

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[246] Mahoney, *Bio-ethics and Belief*, 112

[247] K. Rahner, *Foundations of Christian Faith. An Introduction to the Idea of Christianity*, (London: Darton, Longman & Todd, 1978), 405. See also *Catechism of the Catholic Church*, nn.1817-1821; 2090-2092; McBrien, *Catholicism*, Vol. 2, 973-975. In medieval theology hope was viewed in an individualistic fashion. Since the mid-1960s as a result of the writings of J. Moltmann the theology of hope has been enriched and connected more effectively with the eschatological awareness of the Christian community.

[248] 1 Cor.15:14

[249] Keane, *Health Care Reform*, 69-71

[250] The German theologian Walter Kasper well summarises this: "Faith is not simply an intellectual act or an act of the will. It includes the whole man and every aspect of the human reality...It embraces the whole of Christian existence, including hope and love, which can be seen as two

dynamism of charity informs moral choices.[251] It has been claimed that charity influences (1) the way the three dominant principles of medical ethics (beneficence, autonomy, justice) are interpreted; (2) the way the physician-patient relationship is construed; (3) the way certain moral choices are made.[252] Central to this approach is an awareness that all life's experiences are grounded in charity in such a way that the believer views all of life's moments as occasions for a more intense personal assimilation of the shape of the Christ-event.[253]

Two dimensions of faith and hope expressed in charity concern us here: healing and service. Detailed evidence of Jesus' healing ministry has already been given. What is important for the argument here is the way he healed. Frequently Jesus touched the person desiring a cure. Furthermore, "all the crowd sought to touch him, for power came forth from him and healed them."[254] These many instances of physical contact were significant in a society with social and religious rules governing what one could or could not touch. Jesus touched many ritually unclean people: lepers, the dead, a menstruating woman. Touch, therefore, in the Christian scheme of things, is an incarnational, sacramental dimension of care. Closely related to the place of touch in Jesus' healing ministry was the way he was attentive to the voice of suffering and the priority he gave to restoring particular relationships. The two blind men on the road cried out as Jesus passed. When asked for sight, he touched their eyes and they saw.[255] There are several stories in the gospels, too, where parents go to Jesus seeking help for their children. In all of these cases the Lord heals the child and restores the child to his or her parents.[256] On all occasions Jesus' compassion for the sick manifests God's healing power. The believer, likewise, expresses God's compassion in the care of the neighbour by "a touch that heals, a heart that listens, and a healing that restores relationships".[257]

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ways in which faith is realized." quoted by R. A. McCormick, *Health and Medicine in the Catholic Tradition: Tradition in Transition*, (New York: Crossroad, 1984), 31. See also *Catechism of the Catholic Church*, nn.1822-1829, 2093-2094

251 Cf. Aquinas on *caritas* as the *forma virtutum*.

252 Cf. E. D. Pellegrino, "Agape and Ethics: Some Reflections on Medical Morals from a Catholic Christian Perspective" in *Catholic Perspectives on Medical Morals. Foundational Issues*, edited by E. D. Pellegrino, J. P. Langan, and J. C. Harvey, (Dordrecht: Kluwer Academic Publishers, 1989), 277-300. This claim will be analysed in greater detail in 7.4.3 below.

253 Cf. McCormick, "Theology and Bioethics" in *Corrective Vision*, 146

254 Lk.6:19

255 Mt.20:29-34

256 Mk.9:14-29; Lk.9:37-42

257 Casey, *Food for the Journey*, 27

Service of another is the second dimension of Christian charity. In the washing of the disciples' feet at the Last Supper Jesus drives home the message:

> If I, then, the Lord and Master have washed your feet, you should wash each other's feet. I have given you an example so that you may copy what I have done to you.[258]

The Christian is called to personal service of the neighbour after the example of the Good Samaritan.

This exploration of some aspects of the theological virtues of faith, hope and charity has highlighted the ways in which they operate in personal decision-making and behaviour. The protective dimension of faith, the context giving character of hope and the effective role of charity, especially in healing and serving, have provided an explicitly theological basis for the elements of health care to be sketched in the sections that follow. Before doing this, however, it is necessary to note the ways in which these theological orientations have been outlined in the normative medical ethics of the Catholic tradition.

6.2.3 Normative Framework

In 6.1.3 it was argued that the historical and theological perspectives of the Christian tradition contributed a vision of human life in community that transformed the virtuous commitments of believers. In this section I indicate the ways in which this vision is concretised in the arena of medical ethics. In the teaching of the magisterium and the literature of Catholic medical ethics the Christian vision is articulated in some detail.

Earlier, in chapter 3.4.2, I introduced two characteristics of American bioethics, the penchant for regulatory solutions and resort to the courts in cases of conflict, and referred to the prevailing paradigm currently referred to as *principlism.* Principlism was chiefly fashioned and codified by philosophical ethicists working out of an Anglo-American analytic and secular philosophical tradition. An influential text proposing this type of bioethics has been *Principles of Biomedical Ethics* by T.L. Beauchamp and J.F. Childress. Using a small set of concepts, especially the principles of respect for autonomy, beneficence, nonmaleficence and justice an analysis of bioethical issues and cases is elaborated. In less philosophically qualified hands the text has resulted in the use of the principlist approach in a fashion "so formulaic that it has been portrayed as a mechanically applied, ritually intoned,

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[258] Jn.13:14-15

'mantralike' form of analysis."[259] In recent years the approach has come under increasing criticism as bioethics absorbs a wider range of philosophical influences.[260]

The Catholic community has not been quarantened from influences operating in the wider bioethical scene. However, it will be obvious from what has gone before in this chapter that norms for Catholic medical ethics have frequently been presented either by the teaching authority of the Church or developed in the theological literature. Since Vatican Council II the popes[261], Roman Congregations[262] and national episcopal conferences[263] have taught the Catholic community on a range of biomedical issues. In the English speaking world the American and Canadian Bishops' Conferences have published directives and guidelines for use within their respective health care systems. In the U.S.A. efforts to develop a code of hospital directives began in 1946.[264] The most recent form of the *Ethical and Religious Directives for Catholic Health Care Services* was published in 1994.[265] This text revised and updated earlier directives approved by the U.S. bishops in 1971 and 1975. The document has a twofold purpose: it is directed primarily to Catholic health care services but is also offered to Catholic professionals working in other health care settings.

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259 R. Fox, "The Entry of U.S. Bioethics into the 1990s..., in *A Matter of Principles?*, 48. See also R. Gillon, *Philosophical Medical Ethics*, (Chichester: John Wiley, 1986) which has exercised a similar influence within the Australian context.

260 DuBose et al. in their anthology *A Matter of Principles? Ferment in U.S. Bioethics* illustrates this phenomenon.

261 For example, Paul VI's Encyclical *Humanae vitae* on the moral principles governing human procreation (1968); John Paul II: The Apostolic Exhortation, *Familiaris consortio*, on Marriage and the Family (1981); Address to the Pontifical Academy of Sciences, "Biological Research and Human Dignity"(1982); Address to the World Medical Association, "The Ethics of Genetic Manipulation"(1983); Encyclical *Salvifici doloris*, on the meaning of human suffering (1984); Encyclical *Evangelium vitae*, on the value of human life (1994); Cf. A. Flannery, *Vatican Council II. More Postconciliar Documents*, (Dublin: Dominican Publications, 1982); Catholic Health Association of Canada, *Health Care Ethics Guide*, (Ottawa: Catholic Health Association of Canada, 1991), 80-81

262 The Congregation for the Doctrine of the Faith has issued: Declaration on Procured Abortion, *Quaestio de abortu* (1974); Sterilisation in Catholic Hospitals, *Haec sacra congregatio* (1975); Declaration on Euthanasia, *Iura et bona* (1980); Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation, *Donum vitae* (1987).

263 The Australian Catholic Bishops' Conference has issued statements on *Humanae Vitae* (1974); abortion (1978); health (1983); embryo experimentation (1985). For texts see N. Kerr, ed., *Australian Catholic Bishops's Statements Since Vatican II*, (Homebush, NSW: St. Paul Publications, 1985)

264 For a detailed history of the evolution of a code for U.S. Catholic health care see O. N. Griese, *Catholic Identity in Health Care: Principles and Practice*, (Braintree, Mass.: Pope John XXIII Center, 1987), 1-19

265 U.S. Bishops, "Ethical and Religious Directives...," *Origins*, 449-62.

The document is divided into six parts covering social, pastoral and spiritual responsibilities, the professional-patient relationship, the beginning of life, the dying and new partnerships evolving in the U.S.A. with health care organisations and providers.[266] An appendix analyses the question of moral cooperation. The directives themselves cover a wide range of issues: abortion, euthanasia, treatment of rape victims, advance directives for health care decisions, care for the poor, medical or genetic experimentation, treatment for infertitily, prenatal diagnosis, experiments on living embryos or fetuses, surrogate motherhood, in vitro fertilisation, nutrition and hydration for the terminally ill, pain treatment, organ donation, employee rights and responsibilities. The *Health Care Ethics Guide* published in Canada in 1991 builds on an earlier document of 1970 and follows a structure similar to that of the American text just outlined.[267] In Australia no national directives have been published. Many Catholic health care institutions have developed their own ethical guidelines, frequently adapting one or both of the North American documents.[268]

A universal directory on health care was recently published in Rome by the Pontifical Council for Pastoral Assistance to Health Care Workers under the title, *Charter for Health Care Workers*. It emphasises that persons engaged in health care are in the service of life. Service to the sick is viewed as an integral part of the Church's mission and is an expression of her ministry.[269]

Concrete norms governing Catholic involvement in health care have been developed in the medical ethics literature on the basis of a set of basic values and principles. With little or no variation the following values are to be found in most texts of medical ethics: the dignity and social nature of the human person; the value of human life at all its stages; the dignity and inviolability of personal conscience.[270] Three sets of principles for decision-making are elaborated: (1) double effect offers criteria for

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[266] In each section an introduction provides a context for the directives concerning particular health care issues.

[267] Catholic Health Association of Canada, *Health Care Ethics Guide*. Following a preamble and introduction the *Guide* outlines the communal nature of health care, the dignity of the human person, human reproduction, organ donation and transplantation, care of the dying person and research on human subjects.

[268] Mercy Women's Hospital in Melbourne has reprinted in 1994 the Canadian text with minor changes.

[269] *Charter for Health Care Workers*, (Vatican City: Pontifical Council for Pastoral Assistance to Health Care Workers, 1995), nn.1, 5. The body of the text details particular issues relating to procreation, life and death.

[270] Cf. B. M. Ashley and K. D. O'Rourke, *Health Care Ethics: A Theological Analysis*, 3rd.ed., (St.Louis: Catholic Health Association of the United States, 1989), 176-204; Griese, *Catholic Identity in Health Care*, 21-419. See also Kelly, *Medical-Moral Problems*; C.J. McFadden, *Medical Ethics*, 6th. ed., (Philadelphia: F.A. Davis, 1968)

evaluating human acts which have both beneficial and harmful consequences; (2) cooperation permits an agent to discern whether he or she ought to associate with the evil activity of another; (3) the principles of integrity and totality maintain the centrality of physical and psychic wholeness.[271]

The three perspectives used to study the contribution of Roman Catholic medical ethics have built on the earlier analysis of Roman Catholic moral theory. In all three areas Catholic medical ethics displays features congruent with the discipline of moral theology. Having established the coherence and relevance of the medical ethics and moral methodology from within the discipline it is now necessary to argue its relevance to what is occurring within contemporary society. It is to this we now turn.

6.3 CHURCH AND "POLIS"

The Catholic Church sees itself as part of the political community, a perception that has been refined over many centuries. Three particular concepts permit an insight into this evolution and provide a sufficiently detailed background of relevance to the general direction of this thesis. A study of the notion, *religious freedom*, entails a consideration of the way Church and state relate. Since *pluralism* is the dominant modality by which the liberal state operates some attention must be given to the concept particularly in light of the challenge it has posed for the Church's involvement in the political arena. It is against this background that the social mission of the Church will be considered.

6.3.1 Religious Freedom

Pluralism in all its aspects was placed firmly on the agenda of the Catholic Church as a result of developments in thinking about religious freedom. The Second Vatican Council broke decisively with the teaching of the past on this issue. A direct consequence of this was a renewed vigour in the way the Church approached its relations with the world. Previous historical debates about the relation of Church and

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[271] Ashley and O'Rourke propose three sets of principles which explore dimensions of moral responsibility. (1) Common good and subsidiarity look to life in common. (2) The principle of growth through suffering acknowledges that suffering and death are evils. Every effort must be made to eliminate suffering, to preserve and prolong life. When suffering and death are unavoidable they can also have a positive meaning in a person's life and be moments of growth and deeper union with Christ. (3) The principle of stewardship and creativity require acknowledgement of and responsibility for the gifts of nature and grace given in nature and to persons. B.M. Ashley and K.D. O'Rourke, *Ethics of Health Care: An Introductory Textbook*, 2nd. ed., (Washington, D.C.: Georgetown University Press, 1994), 30-54

state were placed in a new framework.. The change freed Catholic moral theology to engage many of the complex issues in the national and international arenas.

From the time of the Roman Empire the Catholic tradition has maintained that all human authority comes from God and that God has entrusted temporal authority to the state and spiritual authority to the Church. Although a separation of powers has been integral to Catholic political thought since the fifth century, the history of Church-state relations has nonetheless manifested a continuing struggle for supremacy by one party over the other.[272] From the Thirty Years' War the principle *cuius regio, eius religio* (the ruler determines the religion) has influenced Catholic teaching into the modern period. The post-Reformation period also functioned with the idea that "error has no rights" which implied that wrong doctrine has no right to be publicly acknowledged or legally protected. Vatican Council I (1869-1870) modified the received position when it adopted the so called *thesis-hypothesis* formula.[273] The *thesis* asserted that the Catholic religion should be legally established by the state and any other religion should not be tolerated. Where, however, Catholics were a minority this teaching could not operate. The *hypothesis* argued for a religious toleration in such situations either because the ideal was impossible or its implementation would be disruptive of public life. This practical compromise governed Church teaching on Church-state relations up until the Second Vatican Council.

The Declaration on Religious Freedom, *Dignitatis humanae*, of Vatican II transformed the Church-state doctrine in Catholic social teaching, in two ways. First, it enlarged the two key notions of *Church* and *society*. Second, it laid aside a retrospective view of history and adopted a prospective view.[274] In doing this the Declaration (1) acknowledged the *fact* that a religiously pluralist society is the necessary historical context for the whole discussion and (2) expanded Pius XII's notion of the juridical state in which government is seen to be constitutional and limited in its function. Civil authority is primarily juridical and is directed to the protection and promotion of human rights and enabling citizens to carry out their

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272 J. B. Hehir, "Church and State" in *The HarperCollins Encyclopedia of Catholicism*, edited by R. P. McBrien, (New York: HarperCollins, 1995), 315

273 The *thesis-hypothesis* rationale was developed earlier by Bishop Dupanloup in response to the *Syllabus of Errors* of Pius IX. This document was a collection of earlier condemnations of modernity. Freedom of speech, of the press, assembly and worship were condemned. Cf. J. L. Hooper, "Dignitatis Humanae" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer, (Collegeville, Minn.: The Liturgical Press, 1994), 287

274 J. C. Murray, "The Issue of Church and State at Vatican Council II", *Theological Studies* 27 (1966): 581-585

duties. (3) The freedom of the Church is the basis of the Church's relation to civil society. The Church claims a negative right - to be free from coercion in the exercise of its spiritual authority and in the way it lives the Christian life as a community.[275]

John C. Murray, considered an influential contributor to the new teaching on religious freedom, argued that "the affirmation of the right to religious liberty rests on a *complex* [author's emphasis] insight, an insight that has theological, political, moral, and juridical dimensions."[276] Theologically, religious liberty is necessary to protect and secure the freedom of the Church to pursue its mission. This principle correlates with the political principle defining the essentially limited nature of governmental power. Juridically and ethically, religious freedom rests on the insight that law has a moral function but does not have the task of enforcing every humanly beneficial activity or of coercively forbidding every moral evil.

Foundational to this new teaching on religious freedom is the Council's renewed appraisal of the Church's role in the world.[277] The two realms of Church and world "compenetrate".[278] "The Church . . . believes it can contribute much to humanizing the family of man and its history through each of its members and its community as a whole."[279] Cooperation of Church and state in the service of the human person is thus a stated principle of the Council. Depending on the context the believing Christian may appeal to two distinct aspects of religious freedom. The first is the freedom found in a community of faith - the empowering that comes to an individual with the gift of faith. The second aspect of freedom relates to the social, political or civic arenas. In the public forum freedom demands immunity from coercion and from any forms of disadvantage. Freedom thus implies no coercion in regard to religious belief and no restraint in the practice of this belief.[280]

Two considerations follow on the teaching on religious freedom developed by Vatican II. The first which will preoccupy us as we consider the role of the Church in a pluralist society can be articulated in the form of two questions: (1) whether the

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275 Murray, "The Issue of Church...," *Theological Studies*, 585-590

276 D. Hollenbach, "The Church's Social Mission in a Pluralistic Society" in *Justice, Peace, and Human Rights. American Catholic Social Ethics in a Pluralistic World*, (New York: Crossroad, 1988), 11-12

277 *Gaudium et spes*, n.40 in Flannery, *Vatican Council II*, pp.939-940

278 Murray, "The Issue of Church...," *Theological Studies*, 603. "That the earthly and the heavenly city penetrate one another is a fact open only to the eyes of faith." *Gaudium et spes*, n.40 in Flannery, *Vatican Council II*, 940

279 *Gaudium et spes*, n.40 in Flannery, *Vatican Council II*, 940

280 Hollenbach, "The Church's Social Mission...," in *Justice, Peace, and Human Rights*, 11

languages of empowerment and of immunity can coexist, and (2) whether the two can work together toward social betterment.[281] The second issue acknowledges an inductive and dialogical way of learning as the Church engages itself with the issues of the world. John Courtney Murray has argued that affirming the right to religious freedom was not a conclusion of theoretical reason and pure logic, but practical wisdom schooled by historical experience. This practical-historical synthesis mediated secular wisdom to the Church and theological insight to the spheres of politics and law. The Church and the world both learned from each other. "The chief implication of this for the social mission of the Church today is that the Church's participation in public affairs must proceed according to a mode of dialogue and persuasion."[282]

6.3.2 Pluralism

A pluralist society displays a high degree of heterogeneity. The term *pluralism* may be used unfavourably of a society to signify its state of disintegration in comparison with an integrated society. It may also be used to contrast the dynamism within modern society with more static societies.[283] Most often today it is used in this second sense. "The central thesis of this form of pluralism is that a liberal society does not need substantive moral agreement over and above basic agreement on the importance of the mutual toleration of diversity."[284] Moral diversity, it is argued, results from the nature of our moral concepts:

> This vision of pluralism is closely allied with the first in the sense that if there is no single, true, objective way of combining values into a rationally grounded, coherent whole, then it could well be argued that it would be wrong for the state to seek to impose a particular structure of values upon society - it is, rather, a matter of individual citizens pursuing a conception of the good in their own way.[285]

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[281] Leon Hooper comments that those who framed *Dignitatis humanae* hoped for positive outcomes on both points. "However, the believer's continuing reluctance to bring religious languages of empowerment into the public forum and the languages of immunity into the life of the church suggest that past theory and practice continue to weigh heavily. Secularists still fear religious languages that turn totalitarian, while religous leaders fear immunities based on claims of independence from the church." J. L. Hooper, "Religious Freedom" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn.: The Liturgical Press, 1994), 826

[282] Hollenbach, "The Church's Social Mission...," in *Justice, Peace, and Human Rights*, 13

[283] M. Hattich, "Pluralism" in *Sacramentum Mundi. An Encyclopedia of Theology*, edited by K. Rahner, Vol. 5, (London: Burns and Oates, 1970), 33

[284] R. Plant, "Pluralism" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 480

[285] Plant, "Pluralism" in *A New Dictionary of Christian Ethics*, 480

Pluralism acknowledges there is no one set of moral values and practices acceptable to all members of society that might be given the force of law.[286] However, in a pluralist society there cannot be a plurality of views about the importance of individual freedom and mutual tolerance. These are foundational values. The law expresses a social consensus that individual freedom and mutual tolerance form the best basis for a society where many different worldviews and lifestyles exist.[287]

Bioethical thinking mirrors diverse and even conflicting views regarding the foundational values pluralism imposes on contemporary society. H.T. Engelhardt is one who accepts these basic non-negotiable values. He argues that in the discipline of bioethics the fundamental project of a medical ethic in a pluralist society is to frame an understanding of how a society will conduct itself in conditions when one view of the good life, or of the nature of man, will not be imposed by force on all.[288] People must live between two worlds, that of their particularistic convictions (what Engelhardt calls their *private conscience*) and the public morality necessary for maintaining a peaceable community. The procedural nature of the morality of secular society should not be dismissed as lacking moral substance. For, as Engelhardt points out, such a morality affirms the centrality of respect for freedom in the moral life. To respect freedom as the core of the moral life means we will be compelled morally to tolerate the loss of some important moral goods, since there can be no way to embody in public policy any good that is contentious.

For Engelhardt the truth of the post-modern condition is that we must live with fragmentation and pluralism because reason cannot establish for *moral strangers* a concrete, content-full common vision of the moral life.[289] "Consequently, the requisite minimum for civil discourse (and the maximum achievable), according to Engelhardt, is that *moral strangers*, lacking a common vision, at least come to a practical, working agreement on *mutual respect* and *the nonuse of others without their permission*."[290] Engelhardt pictures the situation as follows:

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[286] Gascoigne, *Freedom and Purpose*, 10. Among the causes of contemporary pluralism the author lists secularisation, religious and ethical toleration, individualism, the breakup of traditional communities (*ibid.*, 12-13)

[287] Gascoigne, *Freedom and Purpose*, 14; see also G. J. Hughes, "Is Ethics One or Many?" in *Catholic Perspectives on Medical Morals. Foundational Issues*, edited by E. D. Pellegrino, J. P. Langan, and J. C. Harvey, (Dordrecht: Kluwer Academic Publishers, 1989), 173-96.

[288] H. T. Engelhardt, "Bioethics in Pluralist Societies", *Perspectives in Biology and Medicine* 26:1 (1982): 65

[289] Engelhardt, *Bioethics and Secular Humanism*, 96-101, 121-124

[290] L. S. Cahill, "Theology and Bioethics: Should Religious Traditions Have a Public Voice?", *The Journal of Medicine and Philosophy* 17 (1992): 265. Cahill notes that Engelhardt's approach is pessimistic. His ideal for reason is still culture-transcendence, universal persuasiveness, and

> Secular pluralist morality is . . . founded on limits: the limits of reason and of authority. It is unavoidable not because it is so well established but because other views are incapable of generally establishing the right to use force in controlling the lives of unconsenting others. Because of the limitations of our capacity in general rational terms to defend the discovery of a single correct concrete moral order or to establish authority for its imposition, and because of the ever-available intellectual standpoint of the peaceable community, we have a morality that allows many moralities to grow and flourish. The health care of finite men and women presupposes a moral vision of breadth and tolerance.[291]

A quite different view that rejects the tenets of contemporary secular pluralist society is to be found among those who take a social view of the *polis*. Stanley Hauerwas exemplifies this line of thought. He has rejected Engelhardt's contention that we must consider religious convictions as secondary or private when matters of public policy are being discussed. To compromise in this way results in a denial that such convictions have interesting truth value.[292] Furthermore, Hauerwas has rejected an approach to health care and medicine that reduces their functioning solely to the criterion of freedom and its exercise. Rather, he argues, "medicine as a moral practice draws its substance from the extraordinary moral commitment of a society to care for the ill."[293]

During the four hundred years from the Reformation to Vatican Council II religious pluralism was gradually acknowledged as a fact by Catholic teaching, but never accepted in principle. The conciliar teachings "do not affirm the fact of religious pluralism as good *in se*, but they do affirm pluralism as a positive possibility the Church should not simply resist but should engage in the dialogical style of ministry affirmed by *Gaudium et Spes*."[294] This effort engages the Church in issues of theological substance and political style. The theological issue is how a religiously grounded moral vision can be articulated so as to influence the moral consensus of a pluralistic culture without, at the same time, losing its religious foundation and identity. This tension mirrors the already mentioned conflict internal to theology itself, namely that between fundamentalism and modernism. While recognising this

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virtual irrefutability. Where does this leave religious bioethics? Only able to speak normatively to members of a particular religious community.

[291] H. T. Engelhardt, *The Foundations of Bioethics*, (New York: Oxford University Press, 1986), 386

[292] S. Hauerwas, *Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped and the Church*, (Notre Dame, Ind.: University of Notre Dame Press, 1986), 12

[293] Hauerwas, *Suffering Presence*, 13

[294] J. B. Hehir, "Religious Pluralism and Social Policy: The Case of Health Care" in *Catholic Perspectives on Medical Morals. Foundational Issues*, edited by E. D. Pellegrino, J. P. Langan, and J. C. Harvey, (Dordrecht: Kluwer Academic Publishers, 1989), 210-211

tension we must agree with the statement that a "sound theology, far from being a brake on moral pluralism, must itself, and for exactly the same reasons, be many, though not incommensurably or unrelatedly many."[295] The openness to the world inaugurated by Vatican II stands in contrast to neo-scholastic thinking in the decades before the Council. This thought was shaped by an absolutist world-view and a definitive conceptual system, where pluralism was understood to be relativism.[296]

Vatican II officially opened Catholicism to the basic themes of modernity just as the modern world was itself moving into the post-modern age. One of these themes, namely religious freedom, has been discussed above. The Council did not present a coherent vision of pluralism studying it in a systematic fashion. It did, however, suggest certain motifs that expressed its attitude toward the phenomena of pluralism in contemporary society.[297] The call for dialogue between the Church and other groups in any culture indicates a basic willingness to accept the reality of pluralism as the point of departure for discussion and engagement. A second motif was the acceptance by the Council that different realms of human experience and meaning are relatively autonomous. Religion, politics, science, art, social institutions should enjoy their own rightful autonomy and independence in order to realise their distinctive ends, free from interference or undue limitation. The nature and dignity of the human person are central to the Church's appreciation of pluralism. This core anthropological understanding bridges Christian revelation and secular culture:

> In short, in the vision of Vatican II, pluralism elevates the essential task of unity to a more complex, but absolutely essential project. Pluralism is not an end, but a ferment of perspectives and structures calling for a new vision of human life in the world as a symbolically unified project.[298]

Any study of the Church's engagement in a pluralist society such as Australia must bear in mind the external or internal factors that affect its involvements in public life and society. One important influence in Australian society arises from the distinction made in liberal political thinking between the public and private realms. This distinction has facilitated efforts to relegate religious convictions to the private arena putting them on a par with personal preferences such as music, sport or art. The social role and contribution of religion, personal religious convictions and faith communities have been marginalised in public life. Historically the liberal political

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[295] Hughes, "Is Ethics One or Many?" in *Catholic Perspectives on Medical Morals*, 195

[296] N. Rigali, "Pluralism" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn.: The Liturgical Press, 1994), 744.

[297] R. F. Leavitt, "Notes on a Catholic Vision of Pluralism" in *Catholic Perspectives on Medical Morals. Foundational Issues*, edited by E. D. Pellegrino, J. P. Langan, and J. C. Harvey, (Dordrecht: Kluwer Academic Publishers, 1989), 238-244

[298] Leavitt, "Notes on a Catholic...," in *Catholic Perspectives on Medical Morals*, 241

agenda in Australia may have been associated with a desire to exclude the sectarian controversies of eighteenth and nineteenth century Europe from being transported to our land.[299] Because faith communities have thickly textured understandings of what is good for the individual and the community they stand awkwardly within the liberal secular state. The latter deals with them as it does with all other individuals and groups who participate in society. Undoubtedly this impartiality has contributed greatly to effecting just relationships within the modern pluralist state. However, the thinly textured notion of the good that underpins liberal political theory makes it ill equipped to integrate qualitatively different contributions to the good of society. Procedural justice is concerned primarily with justice-as-fairness and thus aims to facilitate progress within society where competing understandings of values and the good are in conflict. I argue, however, that liberal democratic and pluralist societies such as Australia effectively, and in an *a priori* fashion, exclude significant contributions such as that offered by Roman Catholic moral theory. This absence fundamentally deprives our society of important perspectives and resources impoverishing policy development in a range of areas. I argue in this thesis that this is particularly the case for just health care for aged Australians.

6.3.3 The Social Mission of the Church

The Catholic Church sees itself as having a social mission. It wishes its message to influence public affairs.[300] A number of fears arise with assertions such as this. For the believer: is the Church's involvement, even compromise, in the political arena somehow selling the message of the Gospel short? For the non-believer, on the other hand, there is a certain scepticism. How, granted its mission, can the Church *not* have designs on the minds of those whom it addresses? The separation of Church and state is not the removal of Church from society. Wherever religious freedom is acknowledged room is made for the Church's presence and its right to address all

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[299] Cf. Suttor, *Hierarchy and Democracy in Australia*, 243-280; R.C. Thompson, *Religion in Australia. A History*, (Melbourne: Oxford University Press, 1994), 18-24

[300] Current theology speaks of the *public Church* a term coined by Martin Marty in *The Public Church*, (New York: Crossroad Publishing, 1981). The concept of the public Church would appear to be a response to the privatisation of contemporary secularised social existence. In a post-modern and secular context the Church must be *engaged with* but not seek to *control* society. One of the roles of a public Church is to provide the public with alternative visions of what is desirable and possible. It seeks to stimulate deliberation about these, provoke a reexamination of premises and values, and thus broaden the range of potential responses. In this way it deepens society's understanding of itself. Cf. M. J. Himes and K. R. Himes, "The Public Church and Public Theology" in *Fullness of Faith. The Public Significance of Theology*, (New York: Paulist Press, 1993), 23

who will listen. If this voice is to be heard today the presence must be credible. Style of address, idiom as well as content must be appropriate to the audience.[301]

Nineteenth and early twentieth century Catholic social teaching did not seek to mediate between faith and society but rather to defend Christian tradition against the corrosive currents of modernity. This defense was carried out in the arena of a natural law based social ethics. The Catholic insistence on the complementarity of faith and reason thus ironically came to be interpreted in a way that saw them moving on two parallel tracks only extrinsically related to each other. It became difficult to give properly *theological* reasons for the social teaching of the Church or to give an account of how the deepest meaning of Christianity could speak directly to the problems of post-Enlightenment society. During the decades immediately prior to the Second Vatican Council, it became increasingly clear that this solution to the problem of the relation of the Church and the modern world was both historically anachronistic and theologically unsatisfactory. On the historical level the early social encyclicals had Western Europe implicitly in mind as the world to which the Church's mission was to be directed. Further, they assumed that this world shared a unified intellectual heritage in which Christianity and culture had been harmoniously synthesised. Therefore new secular movements such as liberal democracy in the eighteenth century and various forms of socialism in the nineteenth century were regarded not only as betrayals of faith but as cultural heresies as well.[302]

With Vatican II the Church called on the baptised to become a saving presence in the world. This demanded a different way of being present. The Church is not simply a teacher and witness but is also to be a dialogue partner with all people of goodwill in taking responsibility for those tasks which are shared by all. Furthermore, the Church must be innovative in learning those skills that would enable it to engage in dialogue constructively and, at the same time, undertake tasks that take it beyond its usually acknowledged realm of competence.[303] For *Gaudium et spes* the three dimensions of the Church's social mission in the world are (1) the healing and elevation of the dignity of the human person, (2) the building and consolidation of bonds of solidarity in society, (3) the endowment of daily human activity with a deeper meaning and worth.[304] The Church's self-understanding is that, of its very nature, it has a relationship to the world. Part of the Church's covenant relationship with God is a

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301 Hannon, *Church, State, Morality and Law*, 15

302 Cf. Hollenbach, "The Church's Social Mission...," in *Justice, Peace, and Human Rights*, 5

303 Cf. R. G. Simons, *Competing Gospels. Public Theology and Economic Theory*, (Sydney: E.J. Dwyer, 1995), xvi

304 n.40 in Flannery, *Vatican Council II*, 939-940

commitment to live fully in the world. It does not become involved in worldly activities simply under pressure of external circumstances. The Church distinguishes itself from the political community and does not consider itself bound to any political system. The reason for the Church's entry into public or social ministry is the protection and promotion of the transcendent dignity of the human person. The Church sees social, political and economic issues through the prism of the dignity of the person. The logic of Catholic social teaching is embedded in this understanding of social ministry. A concern for human dignity is expressed in a philosophy of human rights. This, in turn, requires a theological conception of ministry in the social system, all in the name of the person.

The legitimation of social ministry in *Gaudium et spes* has resulted in the Church becoming more deeply involved in the political arena. Protection of human dignity and the promotion of human rights necessarily occur in a political context.[305] The social ministry of the Church as presented in the Second Vatican Council has emphasised the Church's ecclesial responsibility for the world. Whether it is possible to shape a moral consensus beyond the community of faith remains as a question. The answer most frequently given is that a limited but significant degree of public consensus on moral questions is possible in the areas of civil law and public policy. For that reason the Church

> defines civil society as both an audience for its teaching and an object of its pastoral care. Its positive view of the state leads it to seek a structured collaborative relationship with the state based on clearly defined competencies and spheres of influence. Finally, it works to achieve coherence and complementarity between the civil and moral law.[306]

This twofold ministry to personal and public life in society requires different modes of discourse, one for the community of faith and the other to engage a more pluralistic public. It has been suggested that this understanding of mission and ministry is open to a number of criticisms. First the Church is liable to compromise itself. Second in speaking to the whole civil body the Church may lose the sharpness of its biblical imagery and inspiration. Finally the Church may be judged as imposing its religious vision on society as a whole.[307] In spite of these dangers

> Roman Catholicism, from the papacy to the parish, has remained a public church. It has been willing to uphold the position that

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305 J. B. Hehir, "Church-State and Church-World: The Ecclesiological Implications", *Catholic Theological Society of America Proceedings* 41 (1986): 58

306 J. B. Hehir, "Policy Arguments in a Public Church: Catholic Social Ethics and Bioethics", *The Journal of Medicine and Philosophy* 17:3 (1992): 354

307 Hehir, "Policy Arguments...," *The Journal of Medicine and Philosophy*, 355

> compromise in human affairs has its merits, that the search for civil consensus is a valid and necessary ecclesial task, and that the church's case can be made at the bar of reason.[308]

Two areas of difficulty confront the Church as it seeks to pursue its social mission. Within the Church a number of theological debates regarding the scope, source and authority of the Church's teaching on social issues are currently taking place.[309] In society increasing specialisation and differentiation is occurring such that for the Church to be effective it must be organised. Counter-pressures try to keep the Church's action in society non-institutionalised. Where this succeeds there is a resulting fragmentation of Church efforts to engage in the social justice debate. To overcome the privatising and fragmenting pressures of a secular pluralist society the Church adopts two approaches to achieve its social mission: (1) emphasis is placed on commonly shared ethical principles and universalisable imperatives and (2) priority is given to the lived reality of Christian identity and experience in the world[310]:

> The casuistry of keeping the Church's engagement in the political order *indirect* involves an endless series of choices and distinctions. But the effort must be made precisely because the alternatives to an indirect engagement are equally unacceptable: either a politicized church or a church in retreat from human affairs. The first erodes the transcendence of the gospel; the second betrays the incarnational dimension of christian faith.[311]

The challenge for the Church, then, in a pluralist society is to probe the possibilities for moral and political consensus in the light of a presumed lack of religious consensus.[312]

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[308] Hehir, "Policy Arguments...," *The Journal of Medicine and Philosophy*, 355

[309] Hollenbach lists "the scope and limits of pluralism with the church; the role of the teaching office; the internal structures of participation and decision-making; the distinction of various ministries in the church; the relation between universal Christian beliefs and the particularities of diverse cultures; the relation of general moral rules and individual conscience, and the relevance of the social sciences to the development of Christian ethics. All of these problems converge in the discussion of the church's role in the promotion of justice." D. Hollenbach, "A Prophetic Church and the Sacramental Imagination" in *Justice, Peace, and Human Rights. American Catholic Social Ethics in a Pluralistic World,* (New York: Crossroad, 1988), 182

[310] Hollenbach, "A Prophetic Church...," in *Justice, Peace, and Human Rights*, 183-184

[311] Hehir, "Church-State...," *Catholic Theological Society of America Proceedings*, 58-59

[312] W. J. Burghardt, "Consensus, Moral Witness and Health-Care Issues: A Dialogue with J. Bryan Hehir" in *Catholic Perspectives on Medical Morals. Foundational Issues*, edited by E. D. Pellegrino, J. P. Langan, and J. C. Harvey, (Dordrecht: Kluwer Academic Publishers, 1989), 226

6.4 SUMMARY AND CONCLUSIONS

6.4.1 Summary

The question as to why Roman Catholic moral theory should be judged relevant to discussion of just health care for aged persons was raised at the beginning of this chapter. Recall, too, that Part II had shown the presence of significant gaps in recent bioethical analysis. This justified an effort to look further for insights and alternatives. Roman Catholic moral theory, it was shown, is well suited to contribute to issues before contemporary society. Chapter 6, therefore, has argued for the relevance of Roman Catholic moral theory to the issues at hand by means of a synthetic presentation of its key ideas. Three perspectives - the historical, the theological and the normative - were used to map the landscape of Roman Catholic moral theory and medical ethics. Because of the influence of liberalism on Australian society it has been important to show that the Church's understanding of religious freedom, pluralism and its social mission point to a religious community committed to involvement with the world the world in general and Australia in particular.

6.4.2 Conclusions

Five conclusions may now be drawn in light of the analysis provided in this chapter. First, Roman Catholic moral theory presents a *relational morality*. In this it differs from the ethical approaches discussed in Part II. For the Catholic Christian the moral life is primarily experiential, historical, relational and covenantal. The biblical witness attests to this. Moral reflection has evolved out of these scriptural and traditional roots and has adapted through the centuries to meet new pastoral needs and insights.

Second, the moral theory sketched in this chapter arises from within a *resource-full* or *resource-rich* community. Faith flows into action. Catholic Christians grow to maturity in a community where the content and teaching of scripture, the self-understanding and lived worship of the tradition, and the guidance or direction of the magisterium have always been present. Within this context the resource-full Catholic community shapes moral identity, is bearer of the moral tradition and constitutes a community of moral deliberation.

Third, Roman Catholic moral theory contributes to public moral discourse and to life in society at the level of values, obligation, virtues and vision. Particular strength is to be found in the community of believers who, because of their vision of what it

means to be human, are able to proclaim an understanding that is both comprehensive and integrating of all elements of the moral life.

Fourth, the medical ethics that has developed within Roman Catholic moral theology brings to the analysis of health care a wider horizon and context based on the Christian vision. Its theological preoccupation offers a particular style of presence in the ministry of healing and in the tasks of health care delivery. Furthermore, in keeping with its emphasis on morality as objective, the Roman Catholic community has sought to articulate principles and norms for medicine and health care that flow from and reinforce the central vision of the tradition. Catholic medical ethics proposes a content, not merely a process, for resolving the challenges of health care today.

Fifth, Roman Catholic moral theory recognises that for the Church to fulfill its mission in the world it must live with a dynamic tension and yet continue to be involved in the market place of public life. The tension exists between the Church's own core beliefs and understandings on the one hand and the need for freedom and pluralism in society on the other. The Church has resisted through the centuries, with varying degrees of success, the temptation to withdraw from the mainstream of public life, to become a sect. The imperative of its social mission for the life of the world arises from the teaching of Jesus given in the New Testament.

CHAPTER 7

PROBLEMATIC QUESTIONS: THEOLOGICAL REFLECTION

7.1 Aging 336

7.1.1 Human Life 336
7.1.2 Death 343
7.1.3 Aging 349
7.1.3.1 The Meaning of Old Age 349
7.1.3.2 Toward a Theology of Aging 354

7.2 Well-Being: A Matter of Health and Illness 359

7.2.1 The Body and Bodily Existence 360
7.2.2 Health and Illness 367
7.2.3 Pain and Suffering 374

7.3 Charity as Christian Care 380

7.3.1 Committed to Caring 380
7.3.2 The Quality of Caring: Agape as Basis of Christian Care 382
7.3.3 The Christian Understanding of Love 383
7.3.4 A Theology of Health Care 390
7.3.5 The Virtuous Health Care Professional 397

7.4 Summary and Conclusions 402

7.4.1 Summary 402
7.4.2 Conclusions 402

CHAPTER 7

PROBLEMATIC QUESTIONS: THEOLOGICAL REFLECTION

Chapter 6 has established that Roman Catholic moral theory has something to say that is relevant to the central issue of this thesis, namely just health care for aged Australians. Chapter 7 builds on this basis as it reflects theologically on the problematic issues previously studied from a humanistic perspective in chapter 2. The same three questions form the agenda of this chapter: *What does it mean to grow old? What does it mean to be healthy or ill? What does it mean to care?* When discussing the meaning of aging the Catholic tradition draws directly on a faith vision that sees human living transformed by the gospel message. The power of that vision can be seen in the way that it contributes to a virtuous old age. Central to this perspective are the related notions of life and death. Theology gives great importance to a clear understanding of the meaning of human life since it is the basic good upon which all else is built. Equally important is the concept of death since an understanding of its place in human life shapes the way human beings live and contributes to how they view the reality of their own aging. The same need for a theologically rich context is required for the analysis of health and illness. Well-being, for the Christian, is a matter *both* of health *and* illness. Both are significant in the theological scheme of things. A conception of health and illness assumes certain understandings of the human body and human bodiliness. Pain and suffering are inevitable and problematic elements in every human life. As we age our bodies slow down and we experience human limitation, pain and suffering. These frequently cause human beings to ponder the paradox and mystery of pain and suffering in human lives. This inquiry assists us to grasp the meaning of health and illness at all stages in the life cycle.

Reflection on the meaning of care earlier, in chapter 2, noted the emergence of an ethic of care in contemporary medicine and health care. This approach argues for a paradigm shift in scientific medicine which until now has primarily focused on curing the patient through technical means. In this chapter I argue that Roman Catholic moral theory offers an approach to care which understands it as part of the Christian teaching on *agape*, love or charity. A theological study of care must incorporate a number of factors. The Christian understanding of care evolved within a community that has long been committed to caring for the sick and vulnerable in society following the example of the Good Samaritan. Care in theological terms

locates the source and motivation of care in the personal relationship the believer has with Christ. This view of care, therefore, goes beyond formal behaviour and demands inner dispositions of mind and heart that express the divine gifts of faith, hope and love. Christian care in its corporate manifestation is best understood through consideration of a theology of health care. Once this is articulated it is possible to inquire how care is implemented in the Catholic health care system and in the lives and activity of virtuous health care professionals as they care for the sick and needy.

In this chapter I argue that the values of Catholic moral theory *frame* the humanistic, socially constructed understandings of aging, well-being and care discussed in chapter 2. These values not only frame but also *transform* our human understanding of them. In a fashion analogous to the way a picture frame transforms the painting or image it encloses so the basic insights of Catholic moral theory transform the humanistic reflection of aging, health/illness and care in important ways. An understanding of human aging is transformed by an understanding of human life and death (7.1). Well-being as a matter both of health and illness when framed by notions of the human body and the realities of pain and suffering is radically altered (7.2). Human caring, likewise, when framed by a Christian understanding of *agape* is profoundly changed both at the level of personal motivation and personal performance (7.3). These three sections constitute chapter 7.

7.1 AGING

A theological reflection on human aging necessitates consideration of two fundamental realities, namely human existence and its termination. For that reason this study will first sketch a theological understanding of human life and then focus on the Christian conception of dying and death. Only then will it be possible to turn to a richly textured notion of aging in human life.

7.1.1 Human Life

From the Christian perspective the life of a human being is a fundamental good underlying all other values. Concrete bodily existence, however, is not the highest value nor is it given an absolute status.[1] Christian belief in the sanctity of human life is derived from the doctrine of God as Creator. Humankind was made in God's

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[1] W. T. Reich, "Life, Prolongation of" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 351

image with power to reason and the capacity to choose. Each individual is infinitely precious to God and made for an eternal destiny[2]:

> '*Human life is sacred* because from its beginning it involves the creative action of God and it remains for ever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life from its beginning until its end: no one can under any circumstance claim for himself the right directly to destroy an innocent human being.'[3]

Human life has, therefore, a unique status in that God impresses onto the human individual his image and resemblance. Human beings are above all other forms of life. These creatures do not mirror the creator in the same way. All life, since it comes from God, has a sacredness about it and demands respect for it belongs to God. The special dignity and sanctity of human life comes from the fact that it bears the image of God. As a result humans are able to know and love the Creator who has set them over all earthly creatures to "rule them, and make use of them, while glorifying God."[4]

The Christian attitude to human life can only be one of reverence. The entire bible affirms the respect due to human life, a respect which extends to every individual from the moment of conception to extreme old age and death.[5] Human life for the

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2 T. Wood, "Life, Sacredness of" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 353

3 *Catechism of the Catholic Church*, n.2258

4 Cf. *Gaudium et spes*, n.12 in Flannery, *Vatican Council II*, 913. Irenaeus envisages the radical God focus of human existence in the words: "gloria enim Dei vivens homo, vita autem hominis visio Dei" (*Against Heresies*, 4,20,7), i.e. the glory of God is the living human and the life of the human is the vision of God. Cf. A. Autiero, "Dignity, Solidarity, and the Sanctity of Human Life" in *Birth, Suffering and Death*, edited by K. Wm. Wildes, (Dordrecht: Kluwer Academic Publisher, 1992), 81. Note there are two emphases in the theological tradition. One interprets the *image* of God in an holistic manner where the whole human being is touched by the divine impress, i.e. he or she is the *icon* of God. The medieval theologians, on the other hand, emphasised what distinguishes the human person from other forms of life. The image metaphor was thus restricted to the faculties of intellect and will in the human person.

5 Ex.20:13; Dt.5:17: "You shall not kill". The prophets refer to the crime of shedding innocent blood (Is.59:7; Jer.22:3; Ez.22:4). In Mt.5:21-26 Jesus extends respect for human life to the inner dispositions of hatred and anger. Paul sees the prohibition against murder as being present in the consciences of all human beings, be they believers or not (Rom.1:29-32). Cf. F.J. Maloney: "Life, Healing and the Bible: A Christian Challenge", *Pacifica*, 8:3 (1995): 324-331 for an excellent survey of the biblical teaching. See also *Gaudium et spes*, n.51 in Flannery, *Vatican Council II*, 954-955; Congregation for the Doctrine of the Faith, "Declaration on Abortion", n.6 in A. Flannery, *Vatican Council II. More Postconciliar Documents*, 443 and "Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation" (*Donum vitae*), *Origins*, 16:40 (1987): 700-703; John Paul II: Encyclical Letter, *Evangelium vitae*, nn.53-54, *Catholic International*, 275-76

Christian is a gift of God.[6] Our right to life, grounded in our divine origin, is the basis of all other human rights, natural and legal, and the foundation of civilised society.[7]

Central to the Christian valuation of human life is the conviction that the human individual is both physical and spiritual.[8] The spiritual principle of human life, the *soul*, is intimately united to the body.[9] The notion that has predominated in Catholic theology since Aquinas holds that the soul is naturally and intrinsically related to the body.[10] It is not a spiritual reality captive in a material prison.[11] The spirit, the soul of each human being is destined for eternal life and is immortal. Because of this the human person is an animated body or an incarnate spirit. Human, bodily existence is the *locus* or *icon* and basis for all the claims individuals make of others in the human community, whether this be expressed in terms of sanctity, worth, dignity or human right.

In recent times theologians have invoked a *consistent ethic of life* or the *seamless garment of life*. Pope John Paul II portrays many of the the issues concerning human life in terms of the *culture of life* and the *culture of death.* Cardinal Bernardin was a proponent of the consistent ethic of life approach arguing its role in life-enhancing

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6 Cf. S.T. II-II, 64, a.4 and a.6 in which Aquinas emphasises life as gift over which we humans do not have absolute dominion. "The understanding of human life as a gift from God is deeply rooted in Christian tradition. When we speak of it as a 'gift', we are forced, as always when speaking of God, to strain the ordinary language of human experience in an attempt to understand a deep mystery. In particular, the creation of an individual human being differs from other gifts because there is no pre-existing recipient. But the analogy has force in showing that our very existence is a sheer gift. We who receive it are completely dependent on the creating giver. We have neither any prior claim nor anything to offer in exchange as a purchase price. God's creation and sustaining of us is a gift because it is utterly free, unconstrained." *Euthanasia and Clinical Practice: Trends, Principles and Alternatives. The Report of a Working Party*, (London: The Linacre Centre, 1982), 37

7 Human rights in Catholic theology are understood to be claims that persons have on society simply on the basis of their being human. All persons have an inherent dignity that transcends social structures. Recent criticism has focused on the idea of human dignity as based on the image of God. It is argued that this doctrine stresses the individual at the expense of the community. In response to this critique recent teaching has offered a more inclusive understanding of human rights as the "minimum conditions for life in community". Cf. T. D. Whitmore, "Human Rights" in *The HarperCollins Encyclopedia of Catholicism*, edited by R. P. McBrien, (New York: HarperCollins, 1995), 643-44

8 Gen.2:7

9 *Gaudium et spes*, n.14 in Flannery, *Vatican Council II*, 914-15; cf. *Catechism of the Catholic Church*, n.365 speaks of the unity of body and soul as so profound that the soul is the *form* of the body, i.e. "it is because of its spiritual soul that the body made of matter becomes a living human body; spirit and matter, in man, are not two natures united, but rather their union forms a single nature."

10 Cf. B. Davies, *The Thought of Thomas Aquinas*, (Oxford: Clarendon Press, 1993), 211-215

11 This is the Platonist doctrine of the human soul.

and life-preserving issues.[12] His proposal is systematic and analogical, applying to issues that are different but have common characteristics. Bernadin's aim was two-fold: to develop a consensus in the Church regarding all life issues and to contribute to the development of public policy on life issues. The consistent ethic approach insists on an inner connection among life issues at the level of principle which is articulated as: *no direct killing of the innocent.* Richard McCormick in his critical analysis of the approach makes two important observations.[13] First, *global prescientific convictions* are having an influence on both individual and social thinking. These convictions are blinding us to the centrality and dignity of the human person while, at the same time, infecting our deliberative processes. Second, McCormick notes "the problematic character of translating the presumption against taking human life into viable derivative applications for practice."[14] It is here, I believe, the American moralist has identified the central weakness in the consistent ethic of life doctrine. Two diverse approaches to life issues cluster around the challenge McCormick poses. McCormick, Keane and others raise the question: "Is human life a value simply in and of itself or does life have value as the foundation of other values?" Their answer is that human life has instrumental value, it exists to serve other values.[15] Traditional Catholic teaching has, after all, maintained that the final end of the human person is happiness with God in heaven.[16] A different answer is offered by Germain Grisez who argues that since

> a person is an organism whose life is his or her concrete reality, bodily life is an intrinsic good of the person. Life is not an instrumental good, with a merely relative value, varying with its usefulness for pursuing or protecting other personal ends.[17]

Grisez's natural law approach emphasises the notion of basic goods and what is involved when we turn against basic goods such as human life. John Finnis, writing in a similar vein, has systematically developed a philosophical rationale for basic goods.[18] One problem with the *basic goods* approach is the lack of clarity regarding the connection

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12 J. Bernardin, *Consistent Ethic of Life*, (Kansas City: Sheed & Ward, 1988)

13 McCormick, *The Critical Calling*, 211-231

14 McCormick, *The Critical Calling*, 231

15 Keane, *Health Care Reform*, 72

16 Thomas Aquinas: S.T.I-II, 1

17 G. Grisez, *The Way of the Lord Jesus*, Vol. 2, 465. Grisez, together with W.E. May, John Finnis, Joseph Boyle and others, constitute a group of contemporary neo-thomist philosophers who exercise an influence on current official Roman Catholic moral thinking.

18 J. Finnis, *Natural Law and Natural Rights*, (Oxford: Clarendon, 1980), 59-133

> between a basic value in its general form and its particular exemplifications. It is hard to see a reason why one should accord overriding importance to any particular instance of sociability or aesthetic experience or play or knowledge or why one should conclude that acting against a particular instance of any of these basic values entails disrespect for the value in general. Certainly the tradition did not draw such a conclusion even with regard to the taking of a particular life.[19]

These two approaches to the value of human life characterise the two main schools of thought current in English speaking Catholic moral and medical reflection.[20]

Both strands of thought, however, accept that our worth before God implies that we have the duty to cherish, protect, and preserve human life. We are required to take the necessary moral means to relieve suffering and eradicate disease. Undertaking this demands respect for the life and physical integrity of each human individual:

> Since human life is an intrinsic good of persons, the requirements of reverence for life include a moral absolute forbidding the intentional killing of the innocent. And since life is a person's concrete reality, love for persons requires expressing reverence for life by cherishing it. This means at least not killing people through negligence. But since life is vulnerable and everyone's life is threatened in many ways . . . cherishing life also means that one should act to protect oneself and others against loss of life. Being affirmative, this responsibility is limited by other responsibilities; but when anyone's life is threatened, there often is a strict and grave obligation to do what one can to protect it.[21]

Vatican II has listed almost twenty anti-life activities in the contemporary world that are judged to be crimes against human life. They range from murder, genocide and torture to degrading working conditions: "all these and the like are criminal: they poison civilization; and they debase the perpetrators more than the victims and militate against the honor of the creator."[22]

Protecting and promoting health are also part of reverence for human life, since life is diminished and threatened by ill health. Because all bodily organs and parts are personal, reverence for life implies respect for the integrity of the human body. Furthermore, since bodily contact between persons is often meaningful and at times either helpful or harmful, reverence for life requires due care in the way humans have bodily contact with others. A further implication arises from the need that persons

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19 J. Langan quoted by his Jesuit colleague Richard McCormick in *The Critical Calling*, 231

20 Cf. B. V. Johnstone, "The Revisionist Project in Roman Catholic Moral Theology", *Studies in Christian Ethics* 5:2 (1992): 18-31

21 Grisez, *The Way of the Lord Jesus*, Vol.2, 468

22 *Gaudium et spes*, n.27 in Flannery, *Vatican Council II*, 928

have for room and mobility in their daily living. Permitting living space and freedom of movement are thus particular dimensions of the respect owed to human life.[23]

Pope John Paul II in a recent encyclical has referred to the *eclipse of the value of life* such that a *culture of death* is widespread in our world. He nominates modern forms of violence that significantly undermine human life: povery, malnutrition and hunger, violence arising from the arms trade, lack of respect for ecological balance and the criminal spread of drugs and the sex industry. All entail grave risks for human life.[24]

A number of consequences follow from the perception of life as a precious and unique gift of God, with the related obligation to care for both health and life. The first and most significant one is that the Christian lives within certain constraints and under certain moral imperatives. The constraints accord with our understanding of the human as creature and as destined for life with God. Life then is not an absolute. It may be let go of when other values are at stake. This is the case in martyrdom (for reasons of principle, conscience, fidelity to God) or when one chooses to forego therapy because of undue burden to self or others.[25] The moral imperatives in the Christian life entail a striving to care for the sick and dying, the undertaking of medical research to alleviate pain and the development of community structures to support people in time of vulnerability, suffering, death and bereavement. This understanding mirrors Callahan's thought described in chapter 4.2.1 where he attempts to get Americans to live with limits in the area of technological medicine and modern health care.

A second implication arising from the Christian understanding of human life concerns the issue of *quality of life*, a matter much discussed in recent Catholic literature.[26] The pressing question is whether quality of life can be used as a morally defensible criterion for withdrawing, withholding or initiating treatment. If it is, what does the criterion mean and how might it be applied? Again, two approaches are current. In dealing with the particularly thorny choices relating to newborns McCormick has explored the way quality of life can be a criterion for determining the *best interests* of the child. What constitutes a life of minimally acceptable quality seen, as far as is possible, from the child's point of view? To answer this question

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23 Cf. Grisez, *The Way of the Lord Jesus*, Vol.2, 468

24 "Encyclical Letter, *Evangelium vitae*", n.10 in *Catholic International* 6:6(1995): 256

25 Cf. Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* on extraordinary or disproportionate means in A. Flannery, *Vatican Council II. More Postconciliar Documents*, 515-516

26 For a review of the literature see L. S. Cahill, "Notes on Moral Theology: 1986. Sanctity of Life, Quality of Life, and Social Justice", *Theological Studies* 48 (1987): 105-14.

McCormick has proposed the criterion of *relational potential* which points to a certain quality of life which we might judge the child would consider worth preserving. The prospect of a level of consciousness adequate for participating in human relationships would appear to be the necessary benchmark for McCormick.[27] In more recent times he has refined the notion of a minimally acceptable potential for relationships by incorporating a number of other elements into the criterion. The child's best interests must also include his or her medical good, patient preferences, the good of the human as human and the good of last resort, that is the good in which one finds the ultimate meaning of life.[28]

The quality of life ethic has been objected to on the grounds that human persons are fundamentally equal.[29] Furthermore, some are uncomfortable with the idea that a life without relationships is not a good for the person. The Australian moralist Brian Johnstone argues for a sanctity of life approach which constructs the issue not in terms of value of life but in terms of the extent of the duty to preserve life. The latter focus manifests a greater respect for fundamental equality. Central to the sanctity of life viewpoint is what the patient can be assumed to desire in light our common humanity. In spite of the above divergence in contemporary Roman Catholic thinking it is arguable whether terms such as *quality of life* and *sanctity of life* need to be in conflict. Both may be judged to have a vital role in moral reflection about human life.[30]

A third implication following on the value of human life is to be found in the role that sanctity of life and quality of life considerations play in the practice of medicine and health care. The governing insight here is that we may never directly attack innocent human life. This is fundamental to the Catholic church's stand on abortion and euthanasia. In health care the principle operates to ensure that services are

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27 McCormick, *How Brave a New World?*, 339-351; see also 383-401. McCormick links the relational potential approach to the Catholic traditional teaching given by Pius XII which states that physical life is an important but limited value serving to make possible the attainment of a more important good, viz., love of God and neighbour. When that good is for physical reasons not accessible then medically dependent life may be permitted to end. For how this approach relates to McCormick's understanding of the status of the embryo see J. F. Rautenberg, "Abortion: Questions of Value and Procedure" in *Moral Theology: Challenges for the Future*, edited by C. E. Curran, (New York: Paulist Press, 1990), 240-63.

28 L. S. Cahill, "Notes on Moral Theology:1986...," *Theological Studies*, 108-109

29 B. V. Johnstone, "The Sanctity of Life, the Quality of life and the New 'Baby Doe' Law", *The Linacre Quarterly* 52:3 (1985): 262-65; J. Connery objects to McCormick's approach fearing that quality of life considerations will be merged with social-utility considerations. Cf. J. R. Connery, "In the Matter of Claire Conroy", *The Linacre Quarterly* 52 (1985): 321-28.

30 D. Brodeur, "Feeding Policy Protects Patients' Rights, Decisions", *Health Progress* 66:2 (1985): 43

offered to every human being. This has direct consequences where health care for the elderly is at stake. A quality of life criterion emphasises the need to weigh the values involved in each particular situation. This is particularly so where there is no obligation to prolong burdensome physical life for someone in the dying process. The quality of life standard also permits us to discriminate between the diverse life-prolonging measures that a society may well choose omit, at some future time, from the health care system.[31]

A final implication regarding the worth of human life arises from the way language is used to describe human life and its value. Religious understandings of concepts create difficulties when we seek to use them in public discourse. The terms *sanctity* and *dignity* are frequently interpreted in a wide variety of ways. The secular world finds the notion of the human being as *the image of God* either difficult to understand or totally meaningless. Likewise terms such as *sanctity* and *dignity* have lost their conceptual anchor and become fragmented.[32] Dilemmas such as these re-emerge at times in the course of this chapter. In an earlier discussion of liberal and communitarian views of society in chapter 3.1.1 this issue was first raised. It was noted there that the language of faith communities, and thus their value system, confronts the thinly textured notion of the good prevalent in the liberal state.

7.1.2 Death

The earliest Jewish thinking about death described it in terms of the spirit departing from the body. The deceased continued to exist in Sheol (the underworld, the abode of the dead) but totally deprived of their human powers.[33] In an ideal world death was seen to come at a ripe old age to a person who still enjoyed undiminished powers.[34] Such a person dies easily and quickly and goes immediately down to Sheol.[35] The ancient Hebrew understood death as the natural end of the human person.[36] It is the consequence of sin.[37] In the psalms there can be found the prayerful hope that death

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31 Keane, *Health Care Reform*, 73-74

32 Cf. Autiero, "Dignity, Solidarity...," in *Birth, Suffering and Death*, 83. Autiero concludes that in public policy debates "it will be ineffective for a Christian to simply invoke terms of his faith. Rather, their meanings, will be widely varied and incoherent. The task, in addressing a secular, morally pluralistic world is to find ways which convey such values and concerns."(*ibid.*, 83)

33 Ps.6:5; 30:9; 88:11; 115:17; Is.38:11,18

34 Gn.25:8; Job 21:23-24; 29:18-20

35 Job 21:13

36 2 S.14:14

37 Gen.2-3

may not be our final end.[38] Only late in the Old Testament period does belief in the resurrection of the dead became explicit.[39]

The New Testament explicitly and unequivocally sees death as the consequence of sin and a punishment for it.[40] All die in Adam but rise to life in Christ.[41] Jesus overcame the power of death by his own death[42]; he has deprived death of its power effectively making the devil as the lord of death completely powerless.[43] Death no longer has power over Christ and for that reason he rules over the living and the dead.[44] The Christian experiences Jesus' victory over death by sharing in his death through the sacraments of baptism and the eucharist.[45] For each human without exception, however, death is a final and unique event.[46]

In the preaching of the early church there was, for a time, an intense expectation that the kingdom of God was close at hand. Many expected to be alive when the Lord returned in glory at the end of time.[47] By the second century, however, eschatological expectation had diminished in Christian consciousness. In the middle ages the death of the individual person became the focus of attention, with particular emphasis being given to the moment of death. This was seen as the point in the human journey where individual destiny was primarily decided. The beatific vision and the resurrection of the individual body rounded out the medieval thinking on death. The Council of Trent in the sixteenth century merely repeated the traditional teaching that death is the consequence of original sin.[48] It was only with Vatican II that a more comprehensive statement was elaborated on death and its universal significance.[49]

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38 Ps.16:10; 49:16; 73:23-28

39 Dn.12:2; In the N.T. (Ac.23:8) a significant group (the sadducees) deny the possibility of resurrection from the dead

40 Rm.5:12-14

41 1 Cor.15:22

42 1 Cor.15:25-26

43 2 Tim.1:10; Heb.2:14

44 Rom. 6:9;14:9

45 Rom.6:2-11; Jn.6:50-51

46 Lk.16:26; see also Jn.9:4,2; 2 Cor.5:10; Gal.6:10

47 The *eschaton.* Cf. 1Thess.4:15,17; 1 Cor.15:15-52. For an outline of N.T. eschatology see A. Y. Collins, "Eschatology and Apocalypticism" in *The New Jerome Biblical Commentary*, edited by R. E. Brown, J. A. Fitzmyer, and R. E. Murphy, (London: Geoffrey Chapman, 1990), 1359-64.

48 H. Denziger and A. Schonmetzer (ed.), *Enchiridion Symbolorum definitionum et declarationum de rebus fidei et morum*, 34th. ed., (Barcelona: Herder, 1967), nn. 1511, 1521; see also *Catechism of the Catholic Church*, nn.400-403, 1008

49 *Gaudium et spes,* nn.18, 22 in Flannery, Vatican Council II, 917-18, 922-24. Cf. McBrien, *Catholicism*, Vol. 2, 1136. More recently the International Theological Commission issued a

The biblical teaching and tradition of the Church have a number of implications for believers. The reality of death forces us to recognise the radical finiteness of human existence. The knowledge each person has of his or her own death is part of the fundamental self-consciousness each individual has as a human person.[50] Death possesses an ambiguous character in human life. In spite of the certainty of death we go on living with the conviction that life does, or at least can, make sense.[51] Death is the horizon that closes off the future. All human possibilities are seen in the context of death, because it brings into existence a responsibility and seriousness that they could scarcely have had otherwise. Death, after all, is not only destructive but brings some degree of unity and coherence and purpose to human life. Individuals can shape and direct their lives with the certainty of future death in mind. They do not have unlimited time at their disposal. Every person has a set amount of time to live and everything has to be arranged in relation to that deadline. Death has a further effect. It frequently exposes the superficiality and triviality of much of what humans count as important and to which they dedicate so much of their resources and energies. Death in a sense puts everything into perspective.[52] The great German theologian, Karl Rahner, tried to sum all this up by saying that death is present as an axiological (or value imparting) moment in every facet of human consciousness.[53] We live together on this planet as persons moving toward death, radically challenged to integrate death into our approach to life.[54]

Recent Catholic theological writing has attempted to provide a richer description of the reality of human death. Karl Rahner and Ladislas Boros have rejected the idea of death as something which simply overtakes us as an impersonal force.[55] Rather they see it as a final and total act of self-disposal, achieved in complete self-possession. Death is something which affects the whole person and engages the person at all levels of his or her being. While this aspect of death may remain hidden from us in

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document exploring questions in eschatology, cf. "Some Current Questions in Eschatology", *The Irish Theological Quarterly* 58 (1992): 209-43. For an excellent critical review of the document see P. C. Phan, "Contemporary Context and Issues in Eschatology", *Theological Studies* 1994 (1994): 507-36.

50 Keane, *Health Care Reform*, 62

51 Death can be an affirmative, even courageous act, e.g Maximilian Kolbe in Auschwitz. A person's death can be understood as redeeming the blameworthy actions of his life e.g. Sydney Carton in Charles Dickens' *A Tale of Two Cities*.

52 Cf. McBrien, *Catholicism*, Vol. 2, 1138

53 K. Rahner, *On the Theology of Death*, (London: Herder & Herder, 1961), 43-44

54 Cf. Keane, *Health Care Reform*, 62

55 Rahner, *On the Theology of Death* and *Foundations of Christian Faith. An Introduction to the Idea of Christianity*, (London: Darton, Longman & Todd, 1978), 435-441; L. Boros, *The Moment of Truth*, (London: Burns & Oates, 1962)

the sudden and tragic deaths that occur, we can catch something of it when those who suffer prolonged terminal illnesses come to die. Because the act of dying engages the whole person it necessitates a profound exercise of human freedom. This will be so even in cases of tragic and sudden death where such an act may remain hidden. Boros characterises what occurs in the act of dying as a final option, a final act where the dying person freely decides in a definitive way for or against God. For contemporary theologians, then, freedom is not seen merely as a matter of arbitrary choice. Nor is human freedom an absolute reality but something conditioned by the person's entire history as a moral agent. This includes the triumphs of grace and the failures of sin that have been present to that point. A final option is not a soft option but a final act of the whole person, summing up who the person has become in the course of a lifetime. In fact, the final option is the person's self-judgment before God.[56]

A second and equally important dimension of this way of thinking about human dying is to view it as a moment of grace, an encounter with the Risen Lord. Even in death God does not abandon us. Death itself becomes God's final providential moment of grace mediated through the presence of the Risen Jesus. The significance of such grace should not be underestimated. Grace frees our freedom for the most important decision a human can make:

> "Without such grace our decision is conditioned by our whole prior history of freedom and grace. Without such grace who would willingly see the face of God? With such grace we are freed to make a real option for life, for God."[57]

This contemporary reappraisal of human death views death as initiating a new and definitive relationship with God. In death, the experience of transcendent value is no longer threatened by sin. Rather, for those who opt for God, the definitive state that is achieved in death brings a continuing state where life is had in its fulness.

Throughout the greater part of history in the West the dying person prepared for death in a ritually organised and public fashion:

> Dying as an art, the *ars moriendi*, included repentance of past sins, and a deep self-awareness. All this occurred in the bed chamber, which now became a public place; both the dying and those in proximity accepted death rather calmly, without very great display of emotion.[58]

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[56] Ormerod argues that Boros's understanding of the *final option* accords with the Council of Trent's teaching on the *grace of perseverance*. N. Ormerod, *Grace and Disgrace. A Theology of Self-Esteem, Society and History*, (Sydney: E.J. Dwyer, 1992), 68

[57] Ormerod, *Grace and Disgrace*, 68

[58] S. G. Post, *Inquiries in Bioethics*, (Washington, D.C.: Geogetown University Press, 1993), 83. Post uses the study by Ph. Ariès *Western Attitudes toward Death: From the Middle Ages to the Present*, where he contrasts the *tame* death just outlined against the *wild* death of modern times.

By the eighteenth century, however, romanticism had altered attitudes to death. It was dramatised and denounced as greedy. Dying, where there was no certainty about life after death, portrayed death as a tragically final break for the dying person. Death thus became a far more hopeless and negative event than ever before, one that was strongly resented. In this scheme of things death gained a greater sting and had eventually to be hushed up. This occcurred most obviously in the late nineteenth century. Both the sick person and the persons around him or her were to be spared anguish. This resulted in the removal of dying and death from the home, where previously it was a family and community event, to the hospital where it became a solitary and lonely experience.[59] Darwinian thought and the materialistic philosophies removed consideration of the soul from the dying experience, making death both burdensome and final. Furthermore, death became a taboo subject. The deceased were now lost in soul as well as in body.[60] One commentator has observed that there is

> no good reason to suggest that in an era of technological gain, people should resign prematurely to the shadow of death. Yet because death is feared in ways that it once was not as our understandings of human nature and spiritual destiny have narrowed, the transition from rebellion to acceptance is not easy. Technological dominance does not facilitate this transition.[61]

Medical technology is frequently offered to the dying person in modern health care systems. As a result hospitals have come to have a near monopoly on death. Quickly and imperceptibly the dying person has come to be treated in the modern health care system like someone who is recovering from surgery. The contemporary denial of death and the rebellion against it in a society mesmerised by technology has its origins in theological anthropology. The result has been that "[s]piritual rites of passage are lost to metallic ones."[62]

A number of social factors have also contributed to making our modern western nations death denying societies.[63] Secularisation, particularly that which has evolved since the eighteenth century is but one factor. Urban life frequently removes people

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See also L. Stone, *The Family, Sex and Marriage in England 1500-1800*, (London: Weidenfeld and Nicolson, 1977), 206-215, 246-253

59 Post observes the American experience of dying during the 19th. century. Efforts were increasingly made to reduce its impact and beautify the process. "Hence the corpse, previously deemed unimportant, became precious and worthy of ornate burial containers." Post, *Inquiries in Bioethics*, 85

60 Post, *Inquiries in Bioethics*, 85

61 Post, *Inquiries in Bioethics*, 85

62 Post, *Inquiries in Bioethics*, 86

63 Cf. E. Becker, *The Denial of Death*, (New York: Free Press, 1973)

from nature and from witnessing the cycle of life and death. The dominance of the nuclear family has contributed to a more intense sense of loss when death of a loved one is experienced. An extension of the average life span from three decades to seven means that the average child will rarely witness the death of siblings, parents, or friends before adulthood. Furthermore, professionals in the funeral industry make it unlikely that the family will have to deal with a corpse.[64] An avoidance of death can also be seen in a number of contemporary lifestyle patterns: great emphasis is being placed on human fitness; advertising seeks to distract and focuses on what offers happiness; there is a growing interest in suicide and euthanasia.[65]

In light of the above reflections on dying a death a number of implications may be drawn. First, death offers the dying and those who care for them a number of important helps. While death is ultimately a solitary experience, to be entered into by each individual person, it need not be a lonely one.[66] The Christian believes that Jesus' death proclaims God is present everywhere, even in death. This gives us hope and courage to face the unknown. Conviction that there is a solidarity among believers, the so called *communion of saints*, directly shapes the Christian experience of dying:

> It invites one to dare to accompany the dying on their journey. It calls us to join in the grieving process, to not distance ourselves from those whom we feel we can no longer help . . . Ultimately, courage allows us to be be helped by others. Many dying persons are a source of wisdom and grace. Their own courage increases ours.[67]

Second, an emphasis on the role of human freedom in much recent theological reflection on dying and death has emphasised a greater integration of the choices involved in the dying process with the entire life-story of the dying person. It makes an wholistic approach - physical, psychological and spiritual - imperative in the care of the dying and those who accompany them on their journey. This has immediate implications for the type of health care offered to people at the end of their lives.

Third, theological and philosophical bioethics must give greater attention to the cultural assumptions existing in a society. Only then will a satisfactory discussion of end-of-life questions be possible. The approach to life, dying and death outlined in this chapter demands that a more comprehensive analysis of a number of important

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64 Post, *Inquiries in Bioethics*, 86

65 Keane, *Health Care Reform*, 62-64

66 Jesus experienced his dying and death as a solitary experience; cf. Mk.14:32-42; Mt.26:36-46; Lk.22:40-46. Jesus words on the cross, "My God, my God, why have you deserted me?" (Mt.27:46) express the utter loneliness of human death.

67 Casey, *Food for the Journey*, 66

issues: the definition of death; the issue of medical treatment versus basic care for the dying; the understanding of terminal illness where coma and the persistent vegetative state (PVS) are judged to be present and the distinction between killing and letting die in the debate about euthanasia.[68]

7.1.3 Aging

The theological reflection on human aging that follows will first consider the way in which aging raises questions of meaning. When this has been completed, a number theological themes that enrich an understanding of aging will be considered.

7.1.3.1 The Meaning of Old Age

It has been claimed that the test of a people is how they behave toward the old.[69] The English language is filled with vestiges of the power once wielded by old people. The words *elder* and *senate* are examples. In pre-literate communities, where so much depended on lived memory and knowledge of tradition, old people were not only esteemed, they were vital to a community's identity and survival. In spite of this old age has always been ambiguous in human experience and human history since it entails two trajectories: a downward curve involving diminishment, pain, suffering, loneliness and isolation and an upward curve of growth and development characterised by growing self-encounter, a greater and deeper expansion of relationships with other persons and a growing encounter with God.[70]

A number of factors influence attempts to analyse aging in contemporary society.[71] These have been canvassed in some detail in chapter 2.1 where four points were

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68 J. J. McCartney, "Issues in Death and Dying (Including Newborns)" in *Moral Theology: Challenges for the Future*, edited by C. E. Curran, (New York: Paulist Press, 1990), 264-269; see also Ashley and O'Rourke, *Health Care Ethics*, 359-365

69 A. J. Heschel, "The Older Person and the Family in the Perspective of Jewish Tradition" in *Aging and the Human Spirit. A Reader in Religion and Gerontology*, edited by C. LeFevre and P. LeFevre, (Chicago: Exploration Press, 1981), 36. The U.S. Catholic bishops in 1976 proposed seven human rights as of special importance to the elderly: the right to life, to a decent income, to a job, to health care, to eat, to a decent home, to equal treatment. See: U.S. Catholic Bishops, "Society and the Aged: Toward Reconciliation. A Statement of the Catholic Bishops of the United States (May 5, 1976)" in *Pastoral Letters of the United States Catholic Bishops*, edited by H. J. Nolan, (Washington, D.C.: National Conference of Catholic Bishops, 1984), 138-45.

70 C. E. Curran, "A Theological Perspective on Aging" in *Moral Theology: A Continuing Journey*, (Notre Dame, Ind.: University of Notre Dame Press, 1982), 101

71 Among the cultural priorities of American (and Australian) society we might note that they are youth-oriented, production-oriented, pill-oriented, speed-oriented, highly mobile, success-oriented, waste-oriented, 'latest-model' oriented, work-oriented, dollar-oriented, cosmetic-oriented, swinging, having versus being, strength-oriented. This has overflowed into care for the elderly. Health care in particular has become increasingly depersonalised. This can be a threat to

made: (1) that people are living longer, especially in the case of women; (2) that early retirement in advanced nations is increasing; (3) that early retirement is usually followed by increased periods of healthy life; and (4) that there is a growing isolation of the elderly, a fact of increasing concern. Cumulatively these factors are creating a crisis of meaning for both the retired and the wider community.[72] Contemporary culture "appears to lack symbols of transcendence and rituals that would give meaning to the experience of growing old."[73] An outcome of this process has been to make aging a medical problem contributing to a view of old age as a pathological state and as an avoidable affliction. This further erodes positive images and meanings of growing old and being old. Hubris is a further element in discussions of old age. Too often the question of aging is explicitly or implicitly posed in terms of what society can and should do for the elderly. Presupposed is the fact that the elderly have nothing to say to the rest of society and nothing to contribute to society at large.[74]

The crisis of meaning about old age challenges aging persons to accept their aging, to appropriate it as a particular stage of life, to give it meaning and to integrate it into their sense of themselves as persons.[75] At the same time it raises issues for the wider community and the Church. For the young-old (55-64 years of age) in particular a lengthened lifespan poses two challenges. Extended retirement, in combination with other social trends such as dispersed families and advances in medicine, have deprived many old people of meaningful social roles. More importantly, retirement is now detached from the experience of physical decline which previously provided the occasion for spiritual growth in old age. As a result

> old age has ceased to be a liminal experience in which men and women are able to plumb th depths of human existence and so enlarge their capacity to encounter the divine. The great unmet opportunity for the church's ministry is to assist the young-old to find a social role and

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the aged who need time, touching and tenderness. R. A. McCormick, *Health and Medicine in the Catholic Tradition: Tradition in Transition*, (New York: Crossroad, 1984), 158

72 M. A. Kimble, "Religion: Friend or Foe of the Aging?", *Second Opinion* 15 (1990): 71-73. The author notes Victor Frankl's claim that "'as the struggle for survival has subsided, the question has emerged: survival for what? Ever more people today have the means to live but no meaning to live for.'"(*ibid.*, 71)

73 Kimble, "Religion…," *Second Opinion*, 71

74 Curran, "A Theological Perspective...," in *Moral Theology: A Continuing Journey*, 95-96

75 Curran, "A Theological Perspective...," in *Moral Theology: A Continuing Journey*, 105. Curran notes that this approach will challenge the commonly accepted notions of society today. An example is the contemporary understanding of employment and work.

> religious meaning in a time of life which holds unique opportunities for self-directed personal growth and service to society.[76]

The bible as a library of books of diverse literary genre originating from different historical, social and religious environments is an obvious starting point for the Christian seeking to understand old age. Apart from the covenant imperative given in the commandment to honour one's parents many of the references directly addressing the experience of old age in the Old Testament are to be found in the liturgical songs or psalms and in the wisdom books of Ecclesiastes or Ecclesiasticus.[77] Psalm 90:9b-10 vividly expresses the frailty of human life:

> Our years come to an end like a sigh. The days of our life are seventy years, or perhaps eighty, if we are strong . . . ; They are soon gone, and we fly away.

A similar message is given by the Preacher who sketches in a poetic fashion the increasing limits of aging:

> When the guardians of the house (the knees) tremble and the strong man (the arms and the thighs) are bent, and the grinders (the teeth) are idle because they are few, and they who look (the eyes) through the windows grow blind, when the doors (the ears) to the street are shut and the sound of the mills (the appetite or the digestive system) is low, when one waits for the chirp of the bird (the elderly are easily awakened) but all the daughters of song (deafness of the aged or their voices become weak and they cannot sing) are suppressed, and one fears heights and perils in the street (aged are fearful of high places and often terrified by street traffic), when the almond tree blooms (white hair) and the locust grows sluggish (the bent figures of the aged and all burdens are difficult to carry) and the caper berry is without effect (the caper-berry was considered an aphrodisiac which no longer helps dwindling sexual powers) because we go to our lasting home (the grave) and the mourners go about in the street (the tragedy of human beings dying is just one more job for the professional).[78]

The elderly fear the vulnerability and the being without resources that come with advanced age. They show an aversion to being dependent.[79] The Old Testament throughout demands respect and care for one's parents with a reverence akin to

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[76] D. Christiansen, ""And Your Elders Will Dream Dreams". Aging, Liminality and the Church's Ministry" in *Reading the Signs of the Times. Resources for Social and Cultural Analysis*, edited by T. H. Sanks and J. A. Coleman, (New York: Paulist, 1993), 128

[77] Referred to by their Hebrew designation Qoheleth and Sirach respectively.

[78] Qo.11:3-5; text and commentary notes taken from J. Cullen, "Koheleth and Old Age", *The Linacre Quarterly* 50:4 (1983): 332

[79] Ps.71:9-10; Sir.3:12-16; 33:20-21; 41:2

religious awe.[80] The analogy between the parent-child relationship and the bond between Yahweh and Israel was commonplace especially in the prophets.[81]

The way God sees the place of the elderly in ancient Israel is to be found in the experience of people at the margins of the covenant community. Many of the great figures of faith in the Old Testament led insignificant lives until they encountered God in their latter years.[82] Their very weakness and insignificance made them vehicles of God's mercy for others. "At the very point, where they seem to be able to do least for themselves, they are most open to God's grace and best fitted to be vessels of that grace for others."[83]

The New Testament assumed the Israelite norms of filial piety, especially the obligation that children support their parents.[84] Widowhood became an established order in the early Church and represented a significant development in the community's care of the elderly. Widows benefited to some extent from the practice of almsgiving in ancient Israel. Their lives were perilous, however, since the death of their husbands deprived them and their children of their main financial support. For that reason the institution of the order of widows in the early Church was directed to the material support of older women without any family.[85] Widowhood thus conferred status on older women in the early Christian community.[86] By the early second century the order of widows had expanded to include younger women who had never married. Consecrated virgins played an important role in the witness of the early Church.[87]

Augustine viewed aging as something natural and to be expected. It is part of God's good creation. The process of aging should lead naturally to death. However, because creation has been afflicted by the Fall many people will never reach old age, but will

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80 Ex.20:12; Dt.5:16; Sir.3:1-18

81 This kind of filial piety is reflected in Thomas Aquinas's classification of filial piety alongside religion as a primordial virtue (S.T. II-II, 101). See below for a more detailed discussion of *pietas* in the tradition.

82 Cf. Abraham (Gen.16:1-2); Eleazar (2 Macc.6:31); Joel 3:1; Anna (Lk.2:36-38); Joseph (Mt.1:20-22;2:13-15); Nathanael (Jn.1:43-51)

83 Christiansen, ""And Your Elders...," in *Reading the Signs of the Times*, 124-125.

84 1 Tim.5:3-4

85 K. Baus, *From the Apostolic Community to Constantine*, in *History of the Church*, edited by H. Jedin and J. Nolan, Vol. 1, (London: Burns and Oates, 1980), 308-313

86 1 Tim.5:9-11; cf. D. Christiansen, "Aged, Care of the" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 14

87 P. T. Camelot, "Virginity" in *New Catholic Encyclopedia*, Vol. 14, (New York: McGraw-Hill, 1967), 702-703

die young. Of those who grow to old age a number will not age well but will suffer debilitating disease. In spite of this, faith offers a glimpse of what should be in human existence. Augustine proclaimed his conviction that the Church's faith enables us to see the meaning of aging in the context of the human journey.[88]

Two approaches to the elderly can be seen in western Europe from the beginning of the Christian era. Roman law guaranteed property rights and, in doing this, assured a place for the elderly parent in the extended family. Early Germanic societies, on the other hand, were constituted as warrior groups gathered around a chief who exerted his influence through a combination of family ties and his own physical strength. When he aged, however, he was in danger of being supplanted by a stronger clan member. With the spread of monasteries an alternative approach grew in importance. Monastic communities provided a haven for the elderly who were able to retire to the monastery. In doing this they avoided defeat by the next generation and thus left the scene of combat gracefully.[89] In the High Middle Ages when commerce and wealth became increasingly significant monasticism contributed in an interesting way to the lives of the elderly. Third Order Franciscans, while living with their families, sought to live the ideal of gospel poverty. These new religious groups undertook the care of the urban poor, especially orphans and the elderly. In doing this they provided the care needed in a new social context thus complementing the role of monasteries which functioned primarily in the country areas. So throughout the medieval period "monasticism was the major vehicle for the Church's response to the needs of the elderly, as well as being a place of ministry for the elderly."[90]

It has been suggested that western European history may be divided into four periods when studying the place of elderly people in society. In the Roman Empire (until the fifth century) and from the High Middle Ages until the industrial revolution there appears to have been, at least in general terms, a degree of stability. The elderly retained power and status because of their recognised control over family finances. In the centuries following the fall of the Roman empire and from the industrial revolution to the present the aged either lacked security or strength or were unable to

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88 C. G. Gonzalez, "An Historical Perspective on the Church and the Elderly", *Journal of Religion and Aging* 6:3-4 (1989): 65

89 It became common for persons in high positions to retire to monasteries toward the end of their lives to prepare for death. Often this entailed the separation of husbands and wives who each took up a religious vocation.

90 Gonzalez, "An Historical...," *Journal of Religion and Aging,* 70

take up the new skills required by the machine age. In both these eras they were displaced and were seen as a burden for those in their middle years.[91]

Vatican II (1962-1965) speaks only briefly and in passing about the elderly in society. Respect for the human person is expressed in the care we show to the aged.[92] As industrial society develops "safeguards should be placed so that the livelihood and human dignity should be protected of those who through age or ill health labor under serious disadvantages."[93] The teaching that children are to care for their parents is repeated.[94] The scope of the obligation is refined when the Council asserts that families who care for aged members must not only provide them with what is necessary but must obtain for them a fair share in the fruits of economic progress.[95]

7.1.3.2 Toward a Theology of Aging

The lives of older people provide the starting point for a theology of aging. A second dimension of aging, however, must not be overlooked. It comes from an awareness that the aging process begins long before the older years have commenced.[96] The great contemporary Jewish thinker, Abraham Heschel, argues that it is a tragedy that old age should come upon us as a shock, something we are unprepared for.[97] So much of our adult lives entails growth in knowledge and skills. This applies particulary in the public realm of things and people external to ourselves. Because of this preoccupation with the external world many are at a loss when dealing with the inner space. Heschel concludes from this that old age may be viewed primarily as a problem of what to do with privacy.[98] Interiority thus becomes the core challenge in the lives of elderly persons today. Rather than being a period of stagnation old age can offer opportunities for inner growth. When prepared for, it can become a time of

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91 Gonzalez, "An Historical...," *Journal of Religion and Aging*, 71-72

92 *Gaudium et spes*, n.27 in Flannery, *Vatican Council II*, 928

93 *Gaudium et spes*, n.66 in Flannery, *Vatican Council II*, 972

94 *Gaudium et spes*, n.48 in Flannery, *Vatican Council II*, 951

95 *Apostolicam actuositatem*, n.11 in Flannery, *Vatican Council II*, 779

96 S. Hiltner, "A Theology of Aging" in *Aging and the Human Spirit. A Reader in Religion and Gerontology*, edited by C. LeFevre and P. LeFevre, (Chicago: Exploration Press, 1981), 53. "[O]ur theology of aging is both a theology for older people and a theology for those preparing to be older." (*ibid.*, 54)

97 Heschel, "The Older Person...," in *Aging and the Human Spirit*, 37.

98 Heschel, "The Older Person...," in *Aging and the Human Spirit*, 37

98 "The goal is not to keep the old man busy but to remind him that every moment is an opportunity for greatness. Inner purification is at least as important as hobbies and recreation."(*ibid.*, p.39)

completion rather than one of decay. The main failure for many in the modern world is a failure to realise that it is in one's youth that the preparation for old age begins.

Everybody assesses old age as either good or bad. This judgment arises from the opinions, beliefs and images about the human experience of growing older or being old accumulated through a lifetime. Theological reflection, too, operates in a climate conditioned by beliefs, images, imagination and narrative.[99] This provides a richly textured understanding of aging that has been developed in recent theology through a consideration of the four themes of time, dependence, poverty and leisure. These elements when woven together contribute to a theology of aging.

The eschatological dimensions of aging provide an important perspective in a theology of aging.[100] Starting with the common human experience of *time* David Tracy, a Catholic theologian at the University of Chicago, has observed the way *clock* time distorts attempts to reflect on the temporality of our being as we are immersed personally in the phenomenon of our own aging. He argues that it is important to remove the everyday model of time from our language and reflection. Otherwise there is little hope that we ourselves or our pressure-ridden, our time-as-a-series-of-atomic-moments society, can face squarely and positively the aging process as one of the most concrete and most profound expressions of ourselves as temporal beings. The liberation of language and experience go hand in hand. If we can break the ordinary notions of time then it may also be possible for us to view our own aging as more than an occasionally glimpsed phenomenon, to be shunned at all costs. Unless people today break the dominant notion of time that rules their lives it may prove impossible to provide a meaningful understanding of the process of aging itself or a meaningful understanding of how the past and the future relate to any present meaning.[101]

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99 For a succinct outline of six religious images of aging see E. E. Whitehead, "Religious Images of Aging: An Examination of Themes in Contemporary Christian Thought" in *Aging and the Human Spirit. A Reader in Religion and Gerontology*, edited by C. LeFevre and P. LeFevre, (Chicago: Exploration Press, 1981), 56-67.

100 D. Tracy, "Eschatological Perspectives on Aging" in *Toward a Theology of Aging*, edited by S. Hiltner, (New York: Human Sciences Press, 1975), 119-34. He sees the task of Christian theology as twofold: reflecting on the Christian tradition and our common human experience and then developing some critical way of correlating the results of these two distinct analyses (*ibid.*, 120). Don Browning, in the Protestant tradition, employs a similar method of congruence. He focuses on the phenomenological description of aging and links it with Erikson's models of generativity/stagnation, integrity/despair. Cf. D. S. Browning, "Preface...," in *Toward a Theology of Aging*, 151-67.

101 Tracy, "Eschatological Perspectives...," in *Toward a Theology of Aging*, 124

Tracy's thesis is that *any* given moment can only be a human experience if it incorporates all three modalities of human time, namely past, present and future, even though the major source of meaning for any given moment may come from the past, the present or the future.[102] The ever present danger is that one only of these dimensions of time becomes the authentic source of human meaning. This same three dimensional view of time has been important for Christian theology which has focused on the past (the traditionalist), the present (the prophetic) and the future (the apocalyptic).[103] Tracy argues that to declare only one dimension as the authentic option is to distort the tradition. It follows from this perspective that the Christian is able to give a positive interpretation to the phenomenon of aging. In fact an attitude of respect and reverence is appropriate for the different ways we experience, either individually or as a society, authentic temporality and aging:

> Perhaps, after all, the Christian tradition can help free us from the consumerist ideal of time as a series of atomic moments that tends to co-opt the young, imprison the mature, and forget the old. As such it may free us for a human recognition of our temporal meaningfulness and the natural reverence we owe ourselves and our fellows as we distinctly experience that temporality most concretely in the process of aging.[104]

What is fundamentally at stake for Tracy in developing a Christian theology of aging is reverence for ourselves as part of nature. It entails a respect for the diversity of that temporal aging self in a way that the integrity or dignity of every human being is affirmed without qualification. The Judaeo-Christian symbol system can disclose precisely that reverence and illuminate that dignity. Theological reflection, therefore, can provide something like an horizon of meaningfulness and an orientation to the value of aging. This, in fact, may help clarify and strengthen the insights about aging arrived at by psychological and social sciences.[105]

The human experience of dependence provides the second point of departure for a theology of aging. For most of our lives, except for periods of grave illnesses or other major setbacks, we can and do ignore the dependence that ties us to our fellow men

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[102] Tracy, "Eschatological Perspectives…," in *Toward a Theology of Aging*, 125

[103] Tracy, "Eschatological Perspectives…," in *Toward a Theology of Aging*, 127

[104] Tracy, "Eschatological Perspectives…," in *Toward a Theology of Aging*, 132

[105] Cf. Tracy, "Eschatological Perspectives…," in *Toward a Theology of Aging*, 133. The Jewish thinker Abraham Heschel makes a similar point when he observes that old age "has the vicious tendency of depriving a person of the present. The aged thinks of himself as belonging to the past. But it is precisely the openness to the present that he must strive for. He who lives with a sense for the Presence knows that to get older does not mean to lose time but rather to gain time. And, he also knows that in all his deeds, the chief task of man is to sanctify time. All it takes to sanctify time is God, a soul, and a moment. And the three are always here." Heschel, "The Older Person..." in *Aging and the Human Spirit*, 42

and women.[106] For Drew Christiansen, a Jesuit theologian who has written extensively on aging, such avoidance is a mistake. Dependence is an opportunity, a call to let ourselves go, to open up to God, to cling in trust to a power beyond our control, to see more clearly than ever the source and end of life. For the elderly to view their own aging in this way it is necessary that the kindness of others mediate this knowledge. The responsibilities of the family, friends and associates of the frail elderly are awesome, for it falls on them to restore the elderly person's trust in life and in the Author of life. "Dependent aging, if you will, is a sacrament of life, and relatives and friends are its ministers."[107]

Paradoxically ministering to the dependent elderly should expand their autonomy at the time when personal powers are diminishing. The kindness of others allows them to glimpse the kindness of God. Dependence on others should be a sign of our more radical dependence on God. Since human freedom is intended to lead us to a deeper union with God, it is an interesting paradox of human living that radical dependence on God establishes fundamental personal independence - an independence in dependence! Thus from the theological perspective, dependent old age should represent a flowering rather than a wilting of human existence:

> Outside of faith, dependence threatens us with subjugation, and our self-assertion may lead to isolation and abandonment. But for those who believe in the Giver of life, the promise hidden in dependence is communion with the Source of life itself.[108]

The experience of poverty in human living offers a third contribution to a theology of aging. As noted in the earlier study of aging in 2.1, American society in its struggle against ageism has paradoxically turned a blind eye to the vulnerability and marginality of late old age.[109] Denying the disabilities and diminishment which come with old age is a kind of reverse ageism in which only active seniors may be seen in public. Such denial promotes a model of free, uncommitted, self-indulgent early adulthood as the goal for all ages. It flattens the life cycle and denies the experience of those whose experience of old age is one of progressive loss and diminishment.[110] An indicator of the social diminishment old people suffer is to be found in the kind of respect shown to them in daily conversation as when people speak with a loud voice

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106 Cf. McCormick, *Health and Medicine in the Catholic Tradition*, 158-159

107 D. Christiansen, "The Elderly and Their Families: The Problems of Dependence", *New Catholic World* 223 (1980): 102

108 Christiansen, "The Elderly...," *New Catholic World*, 104

109 TV programs such as *The Golden Girls* are symptomatic of this.

110 Christiansen, ""And Your Elders Will Dream Dreams...," in *Reading the Signs of the Times*, 125

as if they are all deaf or use simple language as if to the stupid.[111] While loss is an obvious component in the lives of aging persons this does not detract necessarily from their autonomy. The elderly are humiliated when the range of losses is widened by others without justification. Loss of social recognition contributes to the indignity of aging.[112] On this account many experience aging as a journey into material, spiritual and social poverty. This state of affairs has led to an understanding of aging in terms of a poverty that leads to total dependence on God or to proclaiming a justice that gives preference to those at the margins.[113]

The fourth and final contribution toward a theology of aging has been developed through reflection on the role of leisure in human lives. A social ethos that denies the disabilities and diminishment of old age frequently discredits the place of leisure at all stages of the life journey. In the biblical tradition enjoyment of the leisure of old age was regarded as a divine blessing:

> The sense of blessedness in a leisured retirement is tarnished today, however, by its being so commonplace. The sensate culture which dominates the post-industrial world, moreover, confuses leisure with consumerism. Finally, the restriction of leisure to the pursuit of private satisfactions rather than at the service of communal and public goods degrades the role of retirement in old age.[114]

In the ancient world, leisure was valued for the opportunity it gave for participation in public life, for the cultivation of virtue and learning. In the Church leisure provided for the pursuit of contemplative wisdom. Anglo-American culture has not had the same respect for leisure due, in some degree, to the influence of the Protestant work-ethic. The merchandising of recreational activities and lifestyles has also greatly trivialised the opportunities offered by retirement. On the positive side, however, increased opportunities for chosen pursuits have greatly reduced the danger of disorientation and depression that once were common problems for retirees.

In the Judaeo-Christian tradition leisure is intrinsically religious.[115] The Jewish *sabbath* and the Christian *Lord's Day* were intended to allow men and women to

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111 D. Christiansen, "Dignity in Aging: Notes on Geriatric Ethics", *Journal of Humanistic Psychology* 18:2 (1978): 45-46

112 Christiansen develops a number of principles for an ethic of aging based on the notion of personal dignity at the level of social behaviour. Cf. Christiansen, "Dignity in Aging...," *Journal of Humanistic Psychology*, 50

113 The spirituality of "the poor in spirit" has been elaborated on the first beatitude. Cf. M.H. Crosby, *Spirituality of the Beatitudes. Matthew's Challenge for First World Christians*, (Maryknoll: Orbis, 1981), 49-73. The notion of justice-as-preferential-option-for-the-poor will be considered in chapter 8 below.

114 Christiansen, ""And Your Elders Will Dream Dreams...," in *Reading the Signs of the Times*, 125.

115 Cf. H. Rahner, *Man at Play*, (New York: Herder and Herder, 1967)

renew their ties to their Creator and experience their common dignity as creatures. Freed from toil they were freed to enjoy life for its own sake. In the Christian spiritual tradition, moreover, the leisure retirement of monastic life created the necessary conditions for contemplative prayer where Christians could experience a foretaste of their ultimate union with God. Tradition, therefore, provides concrete directions for developing a Christian understanding of leisure. This has yet to be integrated in a satisfactory way into a theology of aging.[116]

The four elements of time, dependence, poverty and leisure just considered contribute to a rich and varied theological understanding of aging and its place in the human journey. I argue that the study just completed shows the theological reflection building on the humanistic perspective of aging discussed in chapter 2. It enlarges the scope of the earlier study by integrating the notion of aging into the theological framework, or frame, of life and death. This analysis of human aging from a theological perspective directly relates to the issue of human well-being. The experience of growing old is directly linked to the degree of health or illness enjoyed by an individual. In fact whether an old person is healthy or ill challenges human inquiry since human well-being may be so problematic as to cause some to question whether growing old is a value at all. It is to the meaning of health and illness that this study now turns.

7.2 WELL-BEING: A MATTER OF HEALTH AND ILLNESS

This section of the thesis explores the theological understanding of health and illness that a Christian brings to any analysis of aging and aged care. It argues that human well-being is a matter *both* of health and illness. This more inclusive appreciation stands sharply at odds with secular evaluations focused solely on physical or mental health. We begin with a consideration of our human bodily state as persons, then consider the notions of health and illness from a theological perspective. The section concludes with a brief consideration of pain and suffering as these influence our bodily status and impinge on our health.

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[116] Christiansen has proposed that there is a need for a spirituality of leisure, not just a spiritual teaching on aging. This may evolve as a set of institutions and practices - retreats, workshops, mid-life development programs, and so on - which will help restore the religious potential found in early old age. Christiansen, ""And Your Elders Will Dream Dreams...," in *Reading the Signs of the Times*, 129

7.2.1 The Body and Bodily Existence

Foundational to an understanding of health and illness, pain and suffering is the notion of human beings as bodily persons. Health and illness, pain and suffering are experienced by persons in their bodily existence. Human bodiliness means more than having a system of organic material; it entails psychological, emotional, spiritual and social dimensions as well. This study of human bodiliness indicates those elements which enrich our understanding of the bodily phenomena of health and illness, pain and suffering. Furthermore, it argues that a nuanced understanding of human bodily existence is central to an appreciation of human aging and the type of care, especially health care, that ought be offered to the elderly.

The pagan world of the late Roman Empire differed greatly from the views that began to circulate in Christian circles. This difference resided in the way the horizons possible for the body were viewed. In the pagan world the body, like society, was there to be administered not changed.[117] Sexual desire and sexual behaviour were unproblematic provided each male citizen fulfilled his civic duty in rearing a family.[118] Far more important for moral philosophers at that time was irrational, erratic and generally uncontrolled behaviour considered unacceptable in men whose primary role was to govern the community.

Christianity broke into a world where the body, and the social order that was responsive to its unchanging needs, dictated all aspects of human life. In doing so it radically challenged the very fabric of civic life. The incarnation of Christ spoke of a God who reached into human existence transforming its bodily character. As the eminent English historian Peter Brown has observed, Christians

> believed that the universe itself had shattered with the rising of Christ from the grave. By renouncing all sexual activity the human body could join in Christ's victory: it could turn back the inexorable. The body could wrench itself free from the grip of the animal world. By refusing to act upon the youthful stirrings of desire, Christians could bring marriage and childbirth to an end. With marriage at an end, the huge fabric of organized society would crumble like a sandcastle touched by the 'ocean-flood of the Messiah'.[119]

In the semitic thought patterns of the Old Testament the human being is not an individualised entity "but an ensemble of diversely qualified relations. He is not

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[117] P. Brown, *The Body and Society*, 31

[118] Homosexual behaviour was not condemned. What was judged harshly was when a free man allowed himself to be the *female* in homosexual relations. This destroyed the hierarchical society in which the free man was above women and slaves.

[119] Brown, *The Body and Society*, 32

someone who has a body but whose existence is corporal."[120] The human person is an animated body and not an incarnate soul. This unitary view of the human individual did not conceive of the soul as an immortal component of the person. At death the soul (Hebrew, *nephesh*) withdraws from mortal flesh and does not survive as a subsistent principle.

There is no Hebrew equivalent corresponding to the Greek idea of *soma* in the Old Testament.[121] In the Septuagint or Greek version of the Old Testament, *soma* is used to denote a range of ideas conveyed by the Hebrew *basar*, flesh, which signified the human in his or her corporeality. The word was used in the Old Testament virtually in the sense of person.[122] The Greek word, *sarx*, also translates as *flesh* but here the emphasis is on the human in his or her creatureliness.[123] Flesh denotes man or woman as a whole, for human beings are made of flesh and are fleshly in their very essence.[124] This biblical view differed from ideas prevalent in Greek philosophy which viewed the human as *having* flesh. Being an enfleshed human was seen to be closely related to the reality of sin in Jewish thinking. The flesh, however, was never interpreted as the actual cause of sin in human existence.[125]

In the New Testament the use of *soma* reflected the wide range of meanings it had in the Greek world of the first century Christian era. In its use the physical dimension of the body was primary.[126] Of the one hundred and forty seven instances of the use of *sarx* in the New Testament ninety one of them are to be found in the Pauline *corpus*, especially in the letters to the Romans and Galatians.[127] Before considering Paul's teaching on the body it is helpful to consider how the human body was perceived in the gospels.

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120 A. Vergote, "The Body as Understood in Contemporary Thought and Biblical Categories", *Philosophy Today* 35:1 (1991): 96

121 S. Wibbing, "Soma, body" in *The New International Dictionary of the New Testament Theology*, edited by C. Brown, Vol. 1, (Exeter: Paternoster Press, 1980), 232-38.

122 Cf. Lev.15:11, 16, 19; 16:4; 19:28

123 A. C. Thiselton, "Sarx, flesh" in *The New International Dictionary of the New Testament Theology*, edited by C. Brown, Vol. 1, (Exeter: Paternoster Press, 1980), 671-82.

124 Cf. 1 K. 21:27

125 Cf. Is.31:3; Gen.8:21

126 Mk.5:29 ("she felt in her body that she was healed of her disease); Jas.2:16 ("without giving them the things needed for the body"); Mt.6:22 speaks of the eye as the lamp of the body and in Mt.6:25-32 of the body as being more than clothing. These texts point beyond the body as a mere physical organism to the *soma* as signifying the self. Cf. Wibbing, "Soma, body" in *The New International Dictionary of the New Testament Theology*, 234

127 Thiselton, "Sarx, flesh" in *The New International Dictionary of the New Testament Theology*, 674-75

Majella Franzmann's study of gospel texts adapted the social anthropology of Mary Douglas and, in doing so, has opened up a rich understanding of the body in the New Testament. Douglas has proposed the view that the social body constrains the way people perceive the physical body. The physical experience of the body, always modified by the social categories through which it is known, effectively sustains a particular view of society.

> In the study of body imagery as it reflects social order, the treatment of bodily orifices/margins in particular is of great significance since the margins are the places of greatest potential risk and/or power. Images of body orifices symbolise potential vulnerability for the social order. Whatever comes from body orifices, and thus moves across the body boundary, needs especially to be taken into account in societies for which physical or political boundaries are particularly troublesome. [128]

Jesus in the gospels removed a number of taboos applied to the human body. A person's uncleanness is not designated by what enters and issues from bodily orifices.[129] In fact Jesus' own bodily fluids were used to heal the bodies of others.[130] On a number of occasions it is recorded how Jesus touched bodies regarded by his society as unclean or untouchable.[131] Even more importantly all have access to the body of Jesus.[132] Clearly Jesus' own understanding of his body is such that it contributes to the ease with which people can approach him.[133] In light of this Franzmann has concluded that as

> in his healing miracles or table ministry Jesus is the continual contact point between polluted and ritually clean, so in death and resurrected life that praxis is not abandoned. The crucified and risen body of Jesus is the clearest symbol of the broken boundaries since it is at once the totally polluted body and the body in glory.[134]

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[128] M. Franzmann, "Of Food, Bodies, and the Boundless Reign of God in the Synoptic Gospels", *Pacifica* 5 (1992): 22. In regard to food and drink we find Jesus in the gospels placing no restriction on who may be at table with him. In this he challenges the social boundaries of his day by disregarding the already well-entrenched order of eating. (*ibid.*, 24-26)

[129] Mk.7:14-15, 18-23; Mt.15:10-11, 17-20; Lk.11:41

[130] E.g. the use of spit in Mk.7:33; 8:23

[131] E.g. the dead bodies of Jairus's daughter (Mk.5:41; Mt.9:25; Lk.8:54) and the widow's son (Lk.7:14-15); lepers (Mk.1:41-42; Mt.8:3; Lk.5:13). A number of healing miracles restore formerly isolated individuals to their communities of loved ones.

[132] Judas betrayed Jesus with a kiss, the woman who is a sinner approached Jesus at table and anointed him (Lk.7:37-38).

[133] E.g. the woman with the haemorrhage (Mk.5:25-34; Mt.9:20-22; Lk.8:43-48)

[134] Franzmann, "Of Food...," *Pacifica*, 28. Franzmann concludes her study by observing that "one must assert of the Synoptic gospels that Jesus' behaviour with regard to food and bodies exhibits, in general, that same concern for inclusivity one finds in his preaching about the reign of God. The interrelationship of talk about and behaviour toward food and bodies correlates with Jesus' praxis toward those enclosed by many barriers against social mutuality, salvation and even against basic human care and love."(*ibid.*, p.29)

The underlying inflence of Greek thought patterns is obvious in the letters of Paul. His understanding of the human being is a complex one. Not only does he use *sarx* and *soma*, he also speaks of the *psyche* (soul), *pneuma* (spirit), *nous* (mind) and *kardia* (heart).[135] All these terms do not describe parts of the body but rather designate the human person seen from different perspectives as was common in the Old Testament. As noted earlier the human being does not merely have a *soma* but is *soma*, thus referring to the human self.[136] Paul's use of *sarx* "connotes natural, material, and visible human existence, weak and earthbound, the human creature left to itself."[137] This understanding leads him to contrast the *flesh* with the *Spirit*, comparing a human being subject to earthly tendencies with a human being under the influence of God's Spirit.[138]

Paul's use of the concept *body* is theologically rich and subtle. He elaborates his understanding of human bodiliness commencing with the historical, crucified body of Christ (Greek, *soma Christou*).[139] The total, physical, human body of Christ is central to the doctrine of the incarnation just as the risen body of Christ is the central mystery for Christian faith.[140] The bodily resurrection of the Lord is the basis of Christian life and hope. On this basis Paul was able to weave together the following theological insights: (1) the eucharistic body of Christ, (2) the Church as the body of Christ and (3) the body of the believer as a temple of Christ's Spirit. When he wrote about the Church as the body of Christ Paul did not have in mind members of a society governed by a common objective, but rather the idea of Christians as members of Christ. Their union is not only corporate, but somehow corporeal. The unity of Christians is made more complete by their physical consumption of the one

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135 Fitzmeyer, "Pauline Theology" in *The New Jerome Biblical Commentary*, 1406-1407. The use of *psyche* denotes the vitality, consciousness, intelligence and volition of a human being. In using *pneuma* Paul suggests the knowing and willing self and as such that aspect of the person particularly open to receive the Spirit of God. In using *nous* Paul describes the human as a knowing and judging subject; it designates a capacity for intelligent understanding, planning and decision (cf. 1 Cor.1:10; 2:16; Rom.14:5). *Nous* is the capacity to recognise what can be known about God from his creation (Rom.1:20). There is little difference in Paul's use of *nous* and *kardia*. The latter connotes the more responsive and emotional reactions of the intelligent, planning self.

136 Phil.1:20; Rom.6:12-13; cf. 1 Cor.6:15 and 12:27

137 Fitzmeyer, "Pauline Theology" in *The New Jerome Biblical Commentary*, 1406; "No flesh can boast of anything before God" (1 Cor.1:29). "People controlled by the flesh think of what pertains to the flesh"(Rom.8:5); they cannot please God (Rom.8:8). The deeds of the flesh are set forth in Gal.5:19-21. For Paul *flesh* is not restricted to the area of sex, rather he identifies the *ego* and *sarx* and finds no good in them (Rom.7:18)

138 Gal.3:3; 4:29; Rom.8:4-9, 13

139 Rom.7:4

140 1 Cor.15

bread and the one cup of the eucharist.[141] Union in Christ constitutes the Church as the body of Christ.[142] The quality of the believer's union with Christ is clearly demonstrated when Paul condemns all forms of sexual licence as activity that defiles the body of the believer. Physical union with a prostitute affronts the reality of the Christian's bodily existence in Christ. The union with Christ is more than a moral one. Somehow Christ and the Christian share in a union that connotes "one flesh".[143] The Christian living is thus grounded in the historical reality of the physical body of Christ. A living, dynamic union with the unique risen body of the Lord occurs. The corporate union of all Christians is directed to the fullness (the *pleroma*) of the cosmic Christ[144]:

> In the lives of individual Christians this means apostolic suffering that fills up what is lacking in Christ's tribulations on behalf of the Church (Col.1:24). This does not mean that apostolic suffering adds anything to the redemptive value of the cross; rather, such suffering on behalf of the church continues in time that which Christ began, but did not finish in time. It must continue until the cosmic dimensions of the church are achieved.[145]

The establishment of Christianity in the Roman Empire was assisted by a progressive theological articulation of the central mysteries of the faith. This occurred principally when understandings of the faith were refined in light of a number of heresies that attacked Jesus' humanity, his risen bodily existence and his relationship to the other persons of the Trinity, the so-called christological and trinitarian controversies. The notion of *person* was central to this theological evolution.[146] The major role played by the body in Christian soteriology is most clearly apparent in Patristic polemical literature. The incarnate body of Christ contributed greatly to the process of ennobling the human body.[147] A similar clarifying process occurred with the anti-Gnostic polemic.[148] The Gnostic believer sought to redeem his spirit *(pneuma)* from

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141 1 Cor.10:16-17

142 1 Cor.12:27-28; cf. Col.1:18,24; Eph.1:23; 2:16; 4:4

143 1 Cor.6:12-20

144 Eph.1:23

145 Fitzmyer, "Pauline Theology" in *The New Jerome Biblical Commentary*, 1410

146 Cf. G. G. Stroumsa, "*Caro salutis cardo*: Shaping the Person in Early Christian Thought", *History of Religions* 30:1 (1990): 30

147 This is particularly notable in the attack on docetic doctrines. Docetism (from Grk. *dokein,* to seem) attacked the humanity of Christ maintaining that Jesus' humanity, and hence his sufferings, were unreal or phantasmal. See J. N. D. Kelly, *Early Christian Doctrines*, (London: Adam & Charles Black, 1973), 140-141

148 Gnosticism (from Grk. *gnosis*, knowledge) was a system of religious belief according to which salvation depends on a singular knowledge or inner enlightenment about God which liberates a person from the ignorance and evil that characterise the created world. See Kelly, *Early Christian Doctrines*, 22-28

the midst of a corruptible body.[149] Much of Christian anthropology crystallised with the rejection of Gnostic dualism. In all these controversies the Christian tradition proclaimed that "the flesh is the axis of salvation".[150] In fact it is claimed that "the discovery of the person as a unified composite of soul and body in late antiquity was indeed a Christian discovery."[151]

The defensive polemic of the great teachers of the early Church was accompanied by an evolving appreciation of the value of the human body in three areas of Christian life: the witness of martyrs, the lives of monks and the bodies of virgins. First, from the beginning of the Church the bodies of the martyrs were considered sacred. Narratives of their deaths focused on the physical dimensions of their torments. Popular devotion to the relics of martyrs was equally influential. Christians reverenced the bodies of the martyrs in death and believed that they will be raised to life by God on the last day. The sufferings of these witnesses thus became an instrument of defiance to pagan rule and the power of evil.[152] Second, for the monk the task was primarily one of integration. The monk "by virtue of his name, must succeed in unifying his whole person, becoming one on all counts, and remaining alone with himself and Christ, who resides in him."[153] Monastic asceticism did not express contempt for our bodily condition. Rather it was an effort to strengthen not weaken the body. Third, the body of the consecrated virgin became a *locus theologicus* for the Church of the fourth and fifth centuries. The writings of Ambrose (c.339-397AD) are illuminating on this point. In exalting the physical *integritas* of the bodies of virgins and celibates Ambrose portrayed their bodies in terms which saw them as mirroring the experience of the Church body at large as it stood firm against the disintegrating forces of the secular realm. "By reason of the very closedness of her body, the mind, the heart, and the hands of the virgin woman had come to open wide - to the Scriptures, to Christ, and to the poor."[154] For Ambrose the outpouring of Christian vitality associated with baptismal transformation could spill over to embrace society as a whole.

The three exemplars, the body of the martyr, the body of the monk and the body of the virgin indicate a radical appreciation of human bodiliness in the Christian tradition. The

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149 Stroumsa, "*Caro salutis cardo...*," *History of Religions*, 41

150 *caro salutis cardo* is the expression used by Tertullian.

151 Stroumsa, "*Caro salutis cardo...*," *History of Religions*, 44

152 W. A. Meeks, "The Body as Sign and Problem" in *The Origins of Christian Morality. The First Two Centuries*, (New Haven: Yale University Press, 1993), 146

153 Stroumsa, "*Caro salutis cardo...*," *History of Religions*, 39

154 Brown, *The Body and Society*, 363

slowly evolving theology of the sacraments, physical or bodily signs instrumental of God's grace, provide another rich vein of reflection on the place of the human body in Catholic thinking. In recent times theological exploration has insisted on the importance and centrality of the body in the economy of salvation.[155] Great emphasis is now being placed on the unity of body and soul, spirit and matter, within the human composite[156]:

> Wherever we encounter ourselves, wherever we are within our own grasp, as it were, inwardly or outwardly, we have to do with an actual, concrete person. And we can never so to speak materially separate these two from one another. The loftiest spiritual thought, the most sublime moral decision, the most radical act of a responsible liberty is still a bodily perception or a bodily decision. It is still incarnate perception and incarnate liberty - and hence, even by virtue of its own nature, it is still in interplay with everything that is not free, not spiritual, and so on. And conversely, even the most external thing about man is still something that really belongs to the realm of his spirituality; it is still something that is not just mere body.[157]

Bodily existence is thus not something which is added to the spirit of the human being. It is the concrete existence of the spirit itself in space and time. Physical nature or the nature of the human body is not something already existing in itself. It is the self-expression of the spirit reaching out into space and time. These spheres cannot be cleanly separated from one another at the existential level.[158] It follows from this fact that it is a matter of great importance for the human as spiritual person how the material sphere in which he or she lives is constituted.[159] As Karl Rahner observed:

> the body is that through which I fulfil myself in the one world in which all spiritual persons exist. And it is from this starting point that we

[155] K. Rahner, "The Body in the Order of Salvation" in *Theological Investigations*, Vol. 17, (London: Darton, Longman and Todd, 1981), 71-78

[156] In medieval theology Aquinas adopted the hylomorphic theory of Aristotle in an effort to reject the dualism within the tradition. Some scholars, however, consider that Aquinas viewed the human body as a less than perfect partner for the soul at the higher levels of intellectual activity. Only when the corruptible body of this present life is divinely refashioned and becomes incorruptible after death in the beatific vision of the resurrection might there be perfect harmony between them. The Thomistic understanding of what being human means must be understood in terms of the body existing in the world of the soul rather than the opposite. This opinion has weight considering the intellectualist dimension of Thomas's philosophical and theological anthropology and his enduring influence in Catholic theology particularly in this century.

[157] Rahner, "The Body...," in *Theological Investigations*, 82

[158] See also K. Rahner, "The Unity of Spirit and Matter in the Christian Understanding of the Faith" in *Theological Investigations*, Vol. 6, (New York: Crossroad, 1966), 153-77.; K. Rahner, *Hominisation: The Evolutionary Origin of Man as a Theological Problem*, (trans.) W.T. O'Hara, Vol. 13 Quaestiones Disputatae, (New York: Herder and Herder, 1965)

[159] Rahner, "The Body...," in *Theological Investigations*, 87

> should have to think through anew the individual and more specific features of a Christian view of the body.[160]

This re-evaluation of human bodiliness is being pressed on the Church today from a number of different directions as disparate as *in vitro* fertilization and the ordination of women.[161] In the past moral theological discussions about bodily integrity focused on the issue of mutilation. Contemporary questions about bodily integrity raise more radical issues when they ask about the degree to which we can alter the human body without disturbing its human character. Older technologies sought the change the environment external to the human for the *betterment* of human living. New biomedical technologies seek to manipulate the internal environment *bettering* human beings.[162] In the present era the "human body, and hence the human person, is going to be *transfigured* one way or another - through the power of God and/or through the power and genius of human beings."[163]

The theological exploration of the place of the human body and bodiliness in Roman Catholic thinking just completed has provided a detailed basis for the analysis of health and illness that follows. The Christian tradition has been a most important influence contributing to a positive view of the human body. The Christian mysteries of the incarnation and bodily resurrection of Christ have placed our human bodies at the centre of lives directed to service of God and neighbour. For that reason human bodiliness has a pivotal role and value in living a fully human way of life. This is the context within which health and illness are to be understood.

7.2.2 Health and Illness

When we are young good health is often taken for granted. As the years pass our expectations regarding personal health undergo continual revisions. A precise understanding as to the nature of health will often be refined through the experience of sickness, illness or disease. "In the end, sickness reminds us not only of the

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160 Rahner, "The Body...," in *Theological Investigations*, 89

161 Cf. R. Brungs, "Biology and the Future: A Doctrinal Agenda", *Theological Studies* 50 (1989): 700. In contemporary moral theology greater attention is also being given to the notion of embodiment in (1) sexual ethics: cf. K.T. Kelly, *New Directions in Moral Theology: The Challenge of Being Human*, (London: Geoffrey Chapman, 1992), 33; and (2) feminist theology: cf. M. A. O'Neill, "The Mystery of Being Human Together: Anthropology" in *Freeing Theology. The Essentials of Theology in Feminist Perspective*, edited by C. M. LaCugna, (San Francisco: Harper, 1993), 141; S. McFague, *The Body of God. An Ecological Theology*, (Minneapolis: Fortress Press, 1993), 50-52

162 Brungs, "Biology...," *Theological Studies*, 702-703

163 Brungs, "Biology...," *Theological Studies*, 705

mortality of the human person; it reminds us as well of the dignity and worth of human life and human freedom."[164]

Health in the bible is portrayed primarily as a matter of human well-being.[165] The Hebrew word *shalom* in its root meaning designates the fact of being intact or complete.[166] Biblical peace, then, is not merely the state of affairs that permits a tranquil life nor is it simply absence of war. It also suggests the well-being of daily existence, the state of the person who lives in harmony with nature, with self and with God. To be in good health and to be at peace are two parallel notions in the Old Testament.[167] Peace is therefore a relationship that brings happiness, salvation and justice.[168]

While health presupposes a fullness of vital strength, sickness is conceived of as a state of weakness and feebleness.[169] Medical observations in the Old Testament were quite summary and limited to what could be seen: diseases of the skin, wounds and fractures, fever and shaking.[170] The classification of the different diseases was generally vague as can be seen with the term leprosy. The natural causes of ill-health were never given except when they arose from obvious events such as wounding, a fall or old age. In the religious perspective of the ancient world sickness and ill-health were caused by God.[171] Beings superior to the human yet inferior to God were also recognised as causing ill health. Among these were numbered the destroying angel, personified plagues or Satan with demons and evil spirits being seen as the principal cause illness in post-exilic Judaism.[172] Sickness merely gives humans a glimpse of their influence over the world in which they live.

The connection between sickness and sin in the lives of people is important for the Old Testament understanding of sickness. Sickness entered the world because of sin;

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164 Keane, *Health Care Reform*, 65

165 X. Leon-Dufour, ed., *Dictionary of Biblical Theology*, (London: Geoffrey Chapman, 1984), 411-412; H.C. Kee, "Medicine and Healing" in *The Anchor Bible Dictionary*, edited by D. N. Freedman, Vol. 4, (New York: Doubleday, 1992), 659-64.; F. Graber and D. Muller, "Heal" in *The New International Dictionary of New Testament Theology*, edited by C. Brown, Vol. 2, (Exeter: The Paternoster Press, 1976), 163-72.

166 Jb.9:4; e.g. to complete a house (1K.9:25) or the action of reestablishing things in their former state, their integrity - for example to appease a creditor (Ex.21:34), to fufill a vow (Ps.50:14).

167 Ps.38:3-4

168 Leon-Dufour, *Dictionary of Biblical Theology*, 412

169 Ps.38:11; cf. Leon-Dufour, *Dictionary of Biblical Theology*, 543-545

170 Psalms of the sick: Ps.6; 32; 38; 39; 88; 102

171 Ex.4:6; Jb.16:12ff.; 19:21; Ps.39:11f.

172 2S.24:15ff.; 2K.19:35; cf. Ex.12:23 (the destroying angel); Ps.91:5f (plagues); Jb.2:7 (Satan)

in fact it is one of the signs of God's wrath against a sinful world.[173] It has particular poignancy in the context of the covenant since illness is one of the principal curses that afflicts people unfaithful to God.[174] Experience of sickness also brings with it greater awareness of human sinfulness, for that reason the psalms of supplication join a request for a cure with confession of sins.[175] At times the question was raised as to whether all sickness is caused by the sinfulness of person who is sick. The issue does not seem to have been satisfactorily resolved. Prevailing understandings of collective guilt found throughout the Old Testament were also judged to be inadequate.[176] The sickness of the just man posed the greatest dilemma. Two solutions to this evolved over time. Job and Tobit viewed sicknesses as a providential test of the individual's fidelity to God.[177] In the person of the Suffering Servant sickness atones for the faults of sinners.[178]

The Old Testament never forbade recourse to medical help in cases of illness. Isaiah employed them to cure Ezekiel and Raphael did the same for Tobit.[179] Simple remedies were the norm and there is at least one text where the medical profession receives praise.[180] Magical practices connected with idolatrous cults were not tolerated since they often corrupted medicine itself.[181] It is to God above all that the human being must have recourse since God is the master of life; it is he who smites and he who cures.[182] Since God is *the* doctor sick people in quest of a cure should address themselves to God's representatives the priests and the prophets, humbly confessing their sins and praying for the gracious gift of God.[183] Trust in God's goodness at times results in a miracle.[184] Such events were interpreted as a sign that

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[173] Cf. Gen.3:16-19; Ex.9:1-12

[174] Dt.28:21f. 27ff. 35

[175] Ps.38:2-6; 39:9-12; 107:17

[176] Cf. Jn.9:2

[177] Tb.12; Jb.

[178] Is.53:4f.

[179] 2K.20:7; Tb.11:8.llf.

[180] Cf. Is.1:6; Jer.8:22; Wis.7:20; Sir.38:1-8.12f.

[181] 2K.1:1-4; the Mosaic law excluded soothsayers, augurs, sorcerers, charmers, wizards and other figures that offered a means to control or avoid Israel's primary relationship with God. Cf. D.Amundsen and G. Ferngren, "Medicine and Religion: Pre-Christian Antiquity" in *Health/Medicine and the Faith Traditions*, edited by M. Marty and K. Vaux, (Philadelphia: Fortress Press, 1982), 64; R.L. Numbers and D.W. Amundsen, ed., *Caring and Curing. Health and Medicine in the Western Religious Traditions*, (New York: Macmillan, 1986), 5-39. See also 2 Chr.16:12

[182] Sir.38:9ff.14; Dt.32:39; cf. Hos.6:1

[183] Ex.15:26; Lv.13:49ff.; 14:2ff.; cf. Mt.8:4; 1K.14:1-13; 2K.2:21; 8:7ff.

[184] 1 K.17:17-24; 2K.4:18-37; 5

God had stooped down to suffering humanity and eased the pains of the sick. Even though sickness was given meaning in the Old Testament it always remained an evil. The eschatological vision of the prophets looks forward to the removal of all illness and disease in the new world where God will be with his people at the end of time: no more sickness, no more suffering and tears.[185] In a world freed from sin it is the Suffering Servant who will take our ills on himself.[186]

Throughout his public ministry Jesus met sick people. He saw illness and disease as resulting from sin, a sign of the power of Satan over human beings.[187] Because of this he felt pity for the sick and took action to cure all those oppressed by disease or possessed by an evil spirit.[188] Miraculous cures which were seen as signs of the reign of God initiated by Jesus continued in the early Church.[189] While Paul occasionally referred to the charism of healing in the early Christian communities the grace of healing came to be associated with the anointing of the sick.[190] Sickness and ill health thus came to be seen as uniting the person to the sufferings of Christ.[191] Helping the sick and visiting them now came to be viewed as a good deed since Christ is being served in the person of the sick.[192] The sick person is no longer accursed, one from whom people turn away.[193] Rather, he or she is the image and sign of Jesus Christ present in the community.

Earlier in chapter 2.2 it was noted that the modern understanding of health has been defined in its relation to disease - a concept which has undergone an interesting evolution with a related impact on the notion of health. Disease first meant an identifiable degenerative or inflammatory process which, if unchecked, would lead to serious organic illness and sometimes eventually to death. The next step in the evolving understanding was a statistical one. Some diseases came to be identified as deviations from a supposed statistical norm. A person was said to be unhealthy, to have a disease, if he or she was *hypo-* or *hyper-* anything, in other words there was danger of suffering an untoward event such as when high cholesterol disposes to stroke or heart attack. The third step in an evolving conceptualisation of disease arose

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185 Is.35:5-6; 25:8; 65:19

186 Is.53:4-5

187 Lk.13:16

188 Mt.20:34

189 Mk.16:7f.; Ac.3:1ff.; 8:7; 9:32ff.; 14:8ff.; 28:8f.

190 1 Cor.12:9.28.30; Jm.5:14ff.

191 2 Cor.4:10; Col.1:24

192 Mt.25:36

193 Cf. Ps.38:12; 41:6-10; 88:9

from the notion of disease as an inability to function in society. This broader understanding of disease paralleled the World Health Organisation's definition of health as a "state of complete physical, mental, and social well-being, not simply the absence of illness and disease."[194] In light of this evolution of the notion of disease two consequences merit noting here. First, expansion of the notions of health and illness has permitted contemporary medicine to treat the desires (wants, needs) of persons. Callahan's critique on this point has been studied in chapter 4.2.2.1. Second, definitions may have the effect of narrowing the responsibilities we have to people thus excluding from care and concern those whose life is ending or who have no hope of full well-being. This is a particular danger in a high-tech medical environment.[195]

Catholic medical ethicists have incorporated much of this evolving understanding of health and disease into their thinking. Almost always, however, they insist on a more comprehensive definition and understanding which attends to notions of human life, death and bodiliness discussed earlier in this chapter.[196] Together these two emphases provide a basis for the principles of *integrity* and *totality* in Roman Catholic medical ethics. "Although the immediate end or purpose of preserving health traditionally has been confined to physical well-being (totality), it is oriented, by God's will and plan, to the ultimate end of human integrity."[197] The notion of integrity insists that, in the whole, each part must be fully differentiated and developed. Furthermore, each part must fit with the whole and harmonise with it; this results in correct interrelations and interactions between all the parts in the whole. When a part is suppressed, unduly inhibited or hypertrophied to the injury of others, bodily integrity is undermined.[198] Implicit here is an understanding of the human person as a whole and integrated system, with all parts ordered to an integral organism. The principle of integrity has underpinned traditional Roman Catholic analyses of experimentation on human

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194 Cf. McCormick, *How Brave a New World?*, 33-34

195 McCormick, *How Brave a New World?*, 34

196 Ashley and O'Rourke, *Ethics of Health Care*, 25; see also Ashley and O'Rourke, *Health Care Ethics*, 20-43; G. V. Lobo, *Current Problems in Medical Ethics. A Comprehensive Guide to Ethical Problems in Medical Practice*, (Allahabad: St. Paul Publications, 1975), 44-48; B. Häring, *Medical Ethics*, (Slough: St. Paul, 1972), 152-155. Häring considers true health to be "revealed in the self-actualization of the person who has attained that freedom which marshals all available energies for the fulfilment of his total human vocation." (*ibid.*, 154) Grisez, *The Way of the Lord Jesus*, Vol. 2, 519-521. For a detailed analysis of the language of health and disease, particularly as it is applied to aging, see J. Kadlec, "Aging - A New Problem of Modern Medicine", Ph.D. Dissertation, Georgetown University, Washington, D.C., 1981

197 Griese, *Catholic Identity in Health Care*, 205

198 Ashley and O'Rourke, *Health Care Ethics*, 36

subjects, be they embryos or adults.[199] It has always grounded the condemnation of any form of mutilation that destroys bodily integrity. Historically the notion of integrity played a significant role in early analyses of organ transplantation in Catholic medical ethics.[200]

The principle of totality, on the other hand, applies to situations when it is necessary to sacrifice one part or function of the body in the interest of another or of the whole. The argument of Aquinas on this matter has been accepted:

> Since any member is part of the whole human body, it exists for the sake of the whole as the imperfect for the sake of the perfect. Hence a member of the human body is to be disposed of according as it may profit the whole. *Per se*, the member of the human body is useful for the welfare of the whole body; *per accidens* however it can happen that it is harmful, for example, when a diseased member is injurious to the whole body. If, therefore, a member is healthy and continuing in its natural state, it cannot be cut off to the detriment of the whole.[201]

Since 1952 the scope of the principle of totality has been subjected to some discussion among moral theologians. Pius XII extended the Thomistic approach beyond occasions where it is necessary to sacrifice a diseased organ. He judged we are justified in removing a healthy organ from the body of a person for the good of the whole body.[202] More recently Catholic moralists have proposed the adoption of an all-embracing concept of totality such as "the dignity and well-being of man as a person in all his essential relationships to God, to his fellowmen and to the world around him."[203] Except to save life itself, the fundamental functional capacities that constitute the human person should not be destroyed, but preserved, developed, and used for the good of the whole person and of the community.[204]

The Christian is called to choose life and to strive for the fullness of life.[205] Hence there is no place for a passive acceptance of disease or death in this scheme of things. Each person has a moral obligation to preserve and maintain his or her health insofar

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199 The discussion goes back to two addresses by Pius XII in 1952 and 1954 on the limits of experimentation on human subjects. Cf. Kelly, *Medico-Moral Problems*, 265-267

200 Cf. Kelly, *Medico-Moral Problems*, 245-260; see also B. J. Cunningham, *The Morality of Organic Transplantation*, (Washington: Catholic University of America, 1944) who developed Catholic reflection by incorporating the issue of integrity into the wider principle of charity.

201 S.T. II-II, 65,1 quoted in Ashley and O'Rourke, *Health Care Ethics*, 37

202 Ashley and O'Rourke give the example of the removal of healthy testes to suppress hormone production which might stimulate the growth of cancer elsewhere in the body in *Health Care Ethics*, 38; cf. Griese, *Catholic Identity in Health Care*, 217-219

203 Häring, *Medical Ethics*, 62

204 Cf. Ashley and O'Rourke, *Health Care Ethics*, 42

205 John Paul II: "Encyclical Letter *Evangelium vitae*" nn.29-51, *Catholic International*, 265-274

as this is possible.[206] This necessitates a ~~scientifically~~ soundly based knowledge of hygiene, good diet, rest, and exercise. For the Christian, however, health is but one good among a range of human goods. Morally speaking choices relating to health must harmonise with other elements in our human and Christian lives:

> This seldom means that health should be neglected entirely, but it often demands that the means used to protect and promote health be selected and limited to avoid interfering with other areas of life. Of course, one's total vocational responsibilities also can call for special care for one's health; for example, a couple with several young children have a special duty to take good care of themselves so that they will be fully capable of caring for each other and raising their children.[207]

Thus the care for one's health is characterised by moderation and prudence. In contemporary language it favours a preventive approach to illness and an appropriate lifestyle.[208]

The central challenge today is one of meaning. What does it mean to be healthy or ill? The theological explanation goes a considerable way to offering an adequate explanation. If the deeper existential implications of sickness are not recognised, sickness becomes little more than a mechanical failure to be repaired when repair is possible.[209] It has been argued that salvation and holiness have much to do with the wholeness and health of the human person.[210] Because of human sin the path to holiness/wholeness/health entails, at times, painful purification. Illness can be a time of temptation for the patient. For the sick person an important focus should be the spiritual opportunity inherent in his or her situation.[211] Disease and illness come to the believer as a call to further conversion. However, the insecurity and anguish that frequently accompany ill-health may be a cause of temptation. Inactivity, separation from normal life, diminished energy, restricted freedom, together with increased self-centredness, hypersensitivity and irritability all contribute to the burden of

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206 Ashley and O'Rourke, *Ethics of Health Care*, 55

207 Grisez, *The Way of the Lord Jesus*, Vol. 2, 521-522

208 Ashley and O'Rourke, *Health Care Ethics*, 49-51. The authors view this task as expressing the *principle of stewardship and creativity* which they formulate as follows: "The gifts of multidimensional human nature and its natural environment should be used with profound respect for their intrinsic teleology. The gift of human creativity especially should be used to cultivate that nature and environment, with a care set by the limits of human beings' actual knowledge and the risks of destroying these gifts."(*ibid.*, 53)

209 Cf. Keane, *Health Care Reform*, 65

210 Häring, *Medical Ethics*, 156-157. The Protestant theologian William F. May writes in a similar fashion when he notes that "[a]n ancient and positive etymological link exists between 'holy', 'healing', and 'making whole'; between 'salve' and 'salvation'". Cf. *The Physician's Covenant. Images of the Healer in Medical Ethics*, (Philadelphia: The Westminster Press, 1983), 130

211 Theologians speak of *kairos* or saving moments in time differentiating this from *chronos* of chronological moments in time.

sickness.[212] The temptation of ill health arises from an absorption with the struggles of the present which closes off efforts to understand the meaning of the situation, resulting in a rejection, rebellion or escape from what is judged to be an unfair imposition. Illness seen in the light of the paschal mystery (Jesus' suffering, death and resurrection), removes the danger of both patient and doctor concentrating only on the suffering involved.[213] Instead, hope in life should also be present.[214]

This theological understanding of sickness and healing concretely indicates the way in which a faith understanding provides context, motivation and orientation for sick persons and for those caring for them. This has particular relevance for the care of frail or chronically ill elderly persons whose lives run a high risk of being marked by pain and suffering.

7.2.3 Pain and Suffering

In a society where secularism, hedonism and materialism are relatively powerful ideologies the reality of pain and suffering in human lives is a great conundrum. A number of approaches deny that pain and suffering are inevitable. They reject any positive interpretation of this most difficult of human experiences. This has had the result of imposing a rather odd and oppressive judgment on the person who is suffering. Suffering is considered to be avoidable and to be the result of a defective personality structure, a lack of enlightenment, or even irresponsibility:

> If pain and suffering are not understood as part of our human lot but are approached as a correctable dysfunction, then the tragic dimension of human experience undergoes a radical change of status. The sufferer is blamed.[215]

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[212] Illness does not cause the self-centeredness of the sick; rather the sickness itself exposes an already existing egocentrism. Häring, *Medical Ethics*, 164

[213] The important place of the sacrament of the anointing of the sick in Roman Catholic religious practice must be noted here. Through the sacrament the believer who is ill participates in the redemptive sufferings of Christ and provides the Church with a reminder of higher things and of the limitations of human life. The Church's concern for the sick is in fidelity to Christ's command to visit the sick and is consistent with a wholistic understanding of salvation as reaching the total person. Cf. *Catechism of the Catholic Church*, nn.1499-1532; McBrien, *Catholicism*, Vol. 2, 783-788

[214] "The mystery of redemption draws the doctor to the one Redeemer and Healer, for his curative efforts are directed towards the restoration and development of his patient's freedom, and towards the finding of meaning in life and death through increasing altruistic love and service. All the doctor's decisions and attitudes towards the patient are then governed by this view of redemptive liberation integrated with wisdom and a holistic vision. The sick person, on his part, accepts the healing of his bodily and psychic ailments as a symbol and promise of final redemption and liberation." Häring, *Medical Ethics*, 165

[215] Kimble, "Religion...," *Second Opinion*, 74

While a clear differentiation between pain and suffering is almost impossible the two are often separated through designating *pain* as something largely physical and *suffering* as mainly spiritual and mental.[216] What is not contested, however, is that pain is a radical event requiring explanations as to why it and suffering should be present in human life.[217] Both raise questions of meaning.

The meaning of human pain and suffering has challenged human minds from the beginning of time. The Christian who searches for an answer to such questions is confronted by a God who is both radically holy and incomprehensibly mysterious. Acceptance of suffering thus becomes a significant faith event, an experience of trusting in the mysteriousness of the God whom we, like Job in the Old Testament, can never fully understand.[218] The link between faith and suffering is proclaimed most dramatically in the Church's major liturgical season of Lent which ponders the sufferings of the Saviour. In this the Christian does not glorify suffering but rather views suffering as a primarily theological issue.[219]

The bible takes suffering seriously. It does not minimise it, shows profound compassion for the sufferer and sees suffering as an evil which ought not to be.[220] The cries of the suffering were addressed to God in Egypt when the people were in dire need.[221] The prophets in their defence of the true God confronted the scandal of human suffering by proposing that it does not escape God's notice and is, in fact, caused by God.[222] They were, however, unable to explain the prosperity of the wicked and the misery of the just.[223] Bruised by suffering but sustained by their faith the prophets and wise men of the Old Testament gradually entered into the mystery.[224] They discovered the purifying value of suffering which is similar to the

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216 Kelly, *Critical Care Ethics*, 106; others distinguish physical pain from psycho-social-spiritual pain; cf. Catholic Health Association of the United States, *Care of the Dying. A Catholic Perspective*, (St. Louis, Mo.: Catholic Health Association of the U.S., 1993), 27-28

217 Cf. B. V. Johnstone, "Learning through Suffering: The Moral Meaning of Negative Experience" in *History and Conscience. Studies in Honour of Father Sean O'Riordan CSsR*, edited by R. Gallagher and B. McConvery, (Dublin: Gill and Macmillan, 1989), 146

218 Job 42:1-6

219 Keane, *Health Care Reform*, 66

220 Cf. Leon-Dufour, *Dictionary of Biblical Theology*, 586-590

221 Ex.3:7-9; 14:10; Jg.3:9

222 Is.45:7; cf. 63:3-6; Am.3:6; cf. Ex.8:12-28; Is.7:18. The result of this teaching is that the evil person, when confronted with evil in the world, concludes there is no God (Ps.10:4; 14:1), or else there is only a God "incapable of knowledge" (Ps.73:11) and even Job's wife urges him to curse God (Job 2:9)

223 Jer.12:1-6; Hab.1:13; 3:14-18

224 Ps.73:17

way fire separates metal from dross.[225] It is also similar to a father correcting his child and its very swiftness in coming is a sign of the divine good will.[226] They learned to receive from suffering the revelation of a divine plan which confounds human thinking.[227] In time suffering came to be seen as a test which God reserves for servants of whom he is most proud.[228] In the four Servant songs of Isaiah the saving character of the sufferings he endures on behalf of the people are most graphically pictured.[229]

Jesus, the man of sorrows, showed himself sensitive to all human suffering.[230] The miraculous cures and the bringing of dead individuals to life signalled a new era in his person.[231] Suffering in the new dispensation can be a blessing for it prepares the believer to welcome the kingdom.[232] In his own person Jesus experienced human suffering: troubled at the thought of his passion he endured the agony in the garden, experienced betrayal and even abandonment by God.[233] Jesus' redemptive suffering revealed the glory of the Son of God and enabled the Lord to come to the aid of those in trouble.[234]

As the Christian now lives in Christ so the sufferings of the Christian are the sufferings of Christ in the believer.[235] If the believer suffers it is in order to be glorified with Christ.[236] For the Christian this is a privilege.[237] It merits eternal glory after death but also brings joy in this life.[238] There is joy for Paul in the sufferings he endured for he is able to "fill up in his flesh what is wanting to the sufferings of Christ for his body which is the church."[239] Throughout the biblical material the experience of pain and suffering takes on a cosmological dimension a position very

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225 Jer.9:6; Ps.65:10

226 Dt.8:5; Prov.3:11-12; 2 Chr.32:26.31; 2 Macc.6:12-17; 7:31-38

227 Job 42:1-6; cf. 38:2

228 Abraham (Gn.22); Job (Job 1:11; 2:5) and Tobit (Tb.12:13)

229 Is.42:1-9; 49:1-6; 50:4-11; 52:13-53:12

230 Mt.9:36; 14:14; 15:32; cf. Jn.11

231 Mt.11:4; cf. Lk.4:18-19

232 Jn.9:3

233 Jn.12:27; Mt.27:46; Mk.14:33-34; Lk.22:44

234 Jn.17:1; Heb.2:18

235 2 Cor.1:5

236 Rom 8:17; 2 Cor.4:10

237 Phil.1:29; cfl. Ac.9:16; 2 Cor.11:23-27

238 2 Cor.4:17; cf. Ac.14:21; 2 Cor.7:4; cf. Ac.5:41; 1 Pt.4:13-14

239 Col.1:24

different to contemporary philosophical reflection with its individualist and psychological preoccupations.[240]

Pain and suffering attack the integrity of persons - not only those who suffer but also those who accompany the suffering person in their trial.[241] Simone Weil, philosopher and mystic, knew great suffering in her own life and wrote eloquently of its power. She distinguished between what she calls *suffering*, a purely physical phenomenon that passes, and *affliction* (*malheur*) which involves the soul as well as the body. "It takes possession of the soul and marks it through and through with its own particular mark, the mark of slavery."[242] Weil takes us to the heart of the question when she points out that affliction invades and wounds the soul. The person who suffers often experiences a sense of abandonment. People frequently turn from those who suffer, leaving them isolated and alone in their anguish. Suffering involves all dimensions of human life: it speaks in physical pain, wreaks havoc in the soul and impairs human relationships.

Suffering is a uniquely personal experience that involves the whole person. Only the individual can know his or her own suffering. This is part of the anguish of suffering - it can never be fully shared.[243] It is in the inner condition of the one who suffers that the reality of suffering is present. Yet that inner condition is expressed in the physical, bodily signs of pain. This is one reason why more complex kinds of suffering are referred to in terms of physical pain as, for instance, when speaking of the pain of loss or the pain of conscience.[244]

Although the Christian tradition cannot offer a ready explanation or a simple solution to the problem of suffering, it can offer support in suffering and some guidance on how to respond to it. Many images speak to suffering but four of these are particularly significant within Catholic healthcare ministry: the image of God, the compassion of God, the covenant with God and lamentation.[245] Many references have

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240 Anglo-American philosophical texts give scant attention to pain and suffering; no articles are to be found in the *Encyclopedia of Philosophy* and *The Oxford Companion to Philosophy*. Pain and suffering have received a detailed analysis by E.J. Cassell, "Pain and Suffering" in *Encyclopedia of Bioethics*, revised ed., edited by W.T. Reich, Vol.4 (New York: Simon & Schuster Macmillan, 1995), 1897-1904

241 Cf. E. J. Cassel, "The Nature of Suffering and the Goals of Medicine", *The New England Journal of Medicine* (1982): 640-643

242 S. Weil, "The Love of God and Affliction" in *Waiting for God*, (trans.) E. Crawford, (New York: G.P. Putnam's Sons, 1951), 117

243 Casey, *Food for the Journey*, 45

244 Johnstone, "Learning through Suffering...," in *History and Conscience*, 145-146

245 Cf. Casey, *Food for the Journey*, 48

already been made to the way in which each human being is an image of God. Reverence for the person is a powerful imperative calling us to alleviate suffering. Individuals, no matter how ravaged by illness, physically disfigured, mentally impaired or threatened by pain and suffering, call those who serve them to revere God's image in them and, in so doing, to preserve their human dignity. Jewish and Christian theologies in their understanding of the compassion of God speak of a God who stoops down and is present in the sufferings of humanity.[246] The covenant implies that God is responsible for and faithful to his people and that the community of believers are to mirror this to one another, especially by showing care for the vulnerable and the needy. One of the terrible effects of pain and affliction is the loss of language. Pain is difficult to describe, suffering often renders the person mute. There are "forms of suffering that reduce one to a silence in which no discourse is possible any longer, in which a person ceases reacting as a human agent."[247] The tendency of suffering to rob us of language is reinforced by a cultural emphasis on suffering in silence, on keeping a stiff upper lip. Lamentation in the scriptures is the voice of grief, it cries out and gives voice to pain and suffering. The believer is enabled to join his or her sufferings with the generations of those whose anguish has found a voice.[248] Texts such as these convey the message that it is not necessary for a person to suffer in silence or to deny being angry. We can be honest with God and are able to sustain a confidence that God will hear and respond.

Apart from the powerful images just outlined theological reflection has also considered the mystery of pain and suffering from a number of viewpoints.[249] First is the retributive perspective which asks whether God inflicts suffering as a punishment for sin. This has generally been discussed in the context of the broader issue of God and the problem of evil.[250] Second, suffering is considered to have an educative role contributing to the formation of character either as a discipline correcting faults or as positively nurturing virtues such as hope. This entails a learning process in which the individual comes to realise that she or he cannot change things by acting but must endure the pain and suffering. It is, in other words, the learning of patience. As part

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246 Rom.5:6-8

247 D. Soelle, *Suffering*, (trans.) E.R.Kalin, (Philadelphia: Fortress, 1975), 68

248 Cf. the lamentations of Jeremiah (Jer.20:14.18) and the psalms of lament (Pss. 16, 22, 73, 88, 116)

249 This section is influenced by Johnstone, "Learning through Suffering...," in *History and Conscience*, 144-160

250 Theodicy poses the problem by focusing on three elements of the dilemma - God is good and all powerful, but there is great evil in the world. The traditional Christian answer: God is not really responsible for evil, we are. While human sin does inflict pain and suffering, it is not possible to say all physical evils - pain, disease, accident - are caused by human sin.

of sufferings's educative role suffering evokes a contrast experience in which the negation of human wholeness points directly to the positive value which is being violated. From this experience emerges a particular kind of knowledge, an awareness that it is possible to overcome suffering or that a world without tears is possible.[251] Furthermore, it is important to realise the role that remembering and stories play toward grasping the meaning of human suffering. Historical memories not only intensify the contrast experience:

> they enter into our practical consciousness and become the stimulus to conscience. We must not forget those sufferers of the past, lest their sufferings remain, historically and practically, pointless. Yet precisely in remembering what they lost, we are compelled to look to what can be gained today, and in the future . . . In following this commitment we are participating in the action of the redeemer who bore our sufferings, that we might be liberated from them, and who is bringing about the Kingdom where suffering will be no more.[252]

The redemptive dimension of suffering offers a third theological perspective on the mystery of human suffering. Christian spirituality has taught that suffering can be a sharing in the work of redemption achieved through Christ. The passion of Christ reminds us that there is no misery, fear, sorrow, or suffering that is not somehow held in the heart of the one who has chosen to share our existence with us. "In the cross of Christ not only is the Redemption accomplished through suffering, but also human suffering itself has been redeemed."[253] The fourth perspective on suffering is an eschatological one in which Christian hope looks to the vanquishing of suffering, to a new heaven and a new earth where suffering will be no more.

Physical pain is usually the easiest to control yet standard health care is still perceived as doing a poor job in managing it.[254] Most Catholic medical ethics texts consider pain management in relation to the dying person. The American Catholic Bishops' directives on health care are typical in this area:

> Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person even if this therapy may indirectly

[251] Johnstone, "Learning through Suffering...," in *History and Conscience*, 158

[252] Johnstone, "Learning through Suffering...," in *History and Conscience*, 159

[253] John Paul II, *Apostolic Letter: Salvifici Doloris. On the Christian Meaning of Human Suffering*, n.19 (Homebush, N.S.W.: St. Paul Publications, 1984), 44. Martin Luther in his explanation of the theology of the cross "answers the question about suffering and its meaning with God's vulnerability to shame, defeat, and death in the person of Jesus." Kimble, "Religion...," *Second Opinion*, 75

[254] Catholic Health Association of the United States. *Care of the Dying*, 28-30

> shorten a person's life, so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.[255]

This theologically rich understanding of pain and suffering sets the scene for an analysis of the type of care judged central to Christian service of the neighbour. In this chapter human well-being has been considered as a matter both of health and illness. The experience and mystery of pain and suffering which frequently accompanies the aging process is grounded in our human bodies and bodiliness. These elements are the basic building blocks upon which to construct a theological edifice, namely a conception of care that is transformed by *agape* or Christian charity.

7.3 CHARITY AS CHRISTIAN CARE

7.3.1 Committed to Caring

In the earlier consideration of the parable of the Good Samaritan in chapter 3.2 it was observed that the teaching of Jesus on neighbourly behaviour deeply shaped western medical culture. This was reinforced in the Christian community by the requirement that all who profess to follow the Lord should assist the sick and needy without exception.[256] The Jewish roots of Christianity also placed considerable emphasis on the sacred duty of *hospitality*.[257] In the Old Testament the patriarchs are cited as models of this practice particularly after the visit of God to Abraham.[258] This gave a religious character to the Jewish notion of hospitality.[259] In the New Testament hospitality is connected to the Christian's earthly condition as a pilgrim.[260] Hospitality is an expression of love for the guest who is identified with the person of Christ.[261]

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[255] U.S. Bishops. "Ethical and Religious Directives...," n.61, *Origins*, 459; see also Catholic Health Association of Canada, *Health Care Ethics Guide*, n.86; Kelly, *Critical Care Ethics*, 113; Ashley and O'Rourke, *Health Care Ethics*, 386-387

[256] Cf. Mt.25:35-46; S. G. Post, "Love" in *Encyclopedia of Bioethics*, revised ed., edited by W. T. Reich, Vol. 3, (New York: Simon & Schuster Macmillan, 1995), 1393

[257] van Paassen, "Hospitality" in *New Catholic Encyclopedia*, 154-55.

[258] Gn.19:2; 24:17-33; 43:24

[259] Cf. Dt.10:18-19

[260] Heb.11:13

[261] Mt.10:42. Jesus also gave directions as to how the apostles (Mt.10:9-14; Mk.6:10-11) and disciples (Lk.10:5-11) were to accept the hospitality offered by others.

The post-Apostolic period gives many examples of the role of hospitality in the Christian community.[262] In fact, a little later John Chrysostom boasted that the community of Antioch cared for three thousand widows, foreigners and sick each day.[263] The order of deacons was instituted in the early Church because many who were in need were being overlooked.[264] During the second to the fifth centuries deacons fulfilled an established role in the Church assisting all in need. By the fourth century special buildings (*xenodochia*) were constructed to shelter pilgrims and strangers. These expanded to include accommodation for foundlings (*brephotrophia*), orphans (*orphanotrophia*), the sick (*nosocomia*) and the aged (*gerocomia*).[265] In the course of time *xenodochia* became places for the sick. The most significant of the early Christian hospitals was that erected by Basil near Caesarea in Cappadocia around 370 A.D.[266] Many other institutions modelled on Basil's hospital spread throughout the Roman Empire. The duty of hospitality primarily resided with the bishop who frequently delegated the tasks of practical care to deacons. In time practical service of the sick was undertaken by monasteries particularly in the West.[267]

The earliest evidence of episcopal hospitals in western Europe comes from sixth and seventh century Merovingian Gaul. The famous Hotel-Dieu of Paris, supposedly founded in 651 can be documented only as early as 829. Benedictine interest in medicine can be found in manuscripts preserved in monastic libraries. A later development in hospitals, particularly during the crusades, was influenced by the military religious orders such as the Knights Hospitaller of St. John. An increasingly centralised hospital system is to be found in the city-states of the Renaissance period during the late fifteenth century.[268] A survey of subsequent developments in hospitals would distract from the overall direction of this thesis. What has been described makes it sufficiently clear that Christian communities have undertaken care of the sick from the beginnings of the Christian Church. The variety of institutions caring

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262 Clement I of Rome in *1 Clem.*1.2 praised Corinthian hospitality; Ignatius of Antioch insisted on the presence of Christ in guests (*Ad Eph.*6.1); Origen offered two homilies on hospitality (*In Gen.hom.*4-5); Cyprian appointed a priest to care for poor foreigners during his absence (*Epist.*7).

263 *Hom. in Mt.* 66.3

264 Ac.6:1-6

265 Nasalli-Rocca, "Hospitals...," in *New Catholic Encyclopedia*, 159

266 Gregory Nazianzen, a contemporary of Basil, wrote of the hospital in glowing terms. Cf. Gregory Nazianzen, "On St. Basil the Great" in *The Fathers of the Church*, edited by R.J.D. Deferrari, Vol.22, (Washington, D.C.: Catholic University of America Press, 1953), 80-81

267 Cf. Rule of St. Benedict, ch.53

268 Cf. Miller, Risse and Bayley, "Hospital" in *Encyclopedia of Bioethics*, 1160-72; see also McPadden, "Hospitals...," in *New Catholic Encyclopedia*, 163-66

for the sick down through history attest to the high priority Christian tradition has placed on the sick and vulnerable in society. In light of this rich history of care the question has been raised in recent times as to whether recent developments in hospitals have brought about the removal of care as the primary function of such institutions. "Three centuries of medicalization transformed the hospital from a caring shelter for the poor into a disease-oriented machine for the sick who can afford to be cured."[269]

The problematic associated with current health care delivery in a liberal society confronts the contemporary reader of the Good Samaritan parable with a number of significant challenges relating directly to the notion of care. First, how much risk should the modern good samaritan assume when there is conflict between his or her welfare and that of the needy person? Second, how should a good samaritan choose to act if he comes upon the victim while robbers are attacking him? Or, if he meets several victims but is unable to take care of all of them, how might he select who is to receive his care? Third, where there is conflict between what the neighbor needs and wishes and the duty to care, as when a victim requests to be left to die?[270] Many of these issues never entered the mind of the gospel writer. However, because of the Church's understanding of scripture as the revealed word of God, the challenge remains to confront these pressing issues with the resources and orientations offered by the bible as it is read within the community of faith. Repeated readings of the parable of the Good Samaritan challenge contemporary believers, impelling them to act in a neigbourly fashion by caring for the sick and vulnerable. How this is to be implemented in the complexities of the concrete situation calls for a considerable degree of moral discernment, the need for personal conversion and efforts at practical implementation. While the parable does not solve all dilemmas in modern health care it needs to be complemented by questions considering both the motivation and performance of caring behaviour.

7.3.2 The Quality of Caring: Agape as Basis of Christian Care

The Christian commitment to caring for the sick and vulnerable in society attests to the fundamental imperative of Christian discipleship, namely to live as a loving

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[269] Miller, Risse and Bayley, "Hospital" in *Encyclopedia of Bioethics*, 1168

[270] Cf. J. F. Childress, "Love and Justice in Christian Biomedical Ethics" in *Theology and Bioethics. Exploring the Foundations and Frontiers*, edited by E. E. Shelp, (Dordrecht: Reidel, 1985), 225-226

person. For St. Paul the whole Law is summed up in love.[271] Christians consider they have been called to go beyond mere fundamental duties to one another. They accept the fact that certain moral demands call them in a way that secular ethical reasoning denies are obligatory. Christians, therefore, either pursue an ideal in their lives entailing personal choices arising from a particular view of vocation or adopt moral attitudes and actions expected of all Christians. These, too, go beyond what humanist thinking regards as moral duty.[272]

It is important to recall here a point made earlier when discussing *philanthropia* and its usage in the Graeco-Roman world. *Agape* was adopted in the New Testament as the term expressing the type of behaviour expected of the Christian. For the Christian, the notion of *agape* is grounded in the nature of God. It is unlimited, freely given, sacrificial and hence not dependent on the character of its object. *Agape* is an active principle, for love of God requires love of humans. Membership of the kingdom of God depends on such love since where there is no love of neighbour there is no love of God. Jesus' disciples are to be known for their love of one another. *Agape*, love or charity, therefore, is the source and provides the motivation and orientation for all Christian activity, especially that of caring for the ill and needy.[273] This central insight shapes what follows.

7.3.3 The Christian Understanding of Love

The Hebrew verb *aheb* together with its cognates occurs over two hundred times in the Old Testament. It can refer to love between human beings, to love of concrete things or to behavioural qualities, to human love for God or to God's love for individuals or groups. *Hesed* is a term used more frequently in the Old Testament.

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271 Rom.13:10; cf. D. Maguire, *The Moral Core of Judaism and Christianity. Reclaiming the Revolution*, (Minneapolis: Fortress Press, 1993), 211

272 Cf. MacNamara, *Faith and Ethics*, 171-172, 174. The author notes that "[i]f one sees morality in terms of duty/non-duty, one can rather easily apportion moral blame. But if again we return to a notion of virtue, if we see morality on a scalar model, then all falling short of the perfection of Christian life is some moral imperfection, some failure." (*ibid.*, 175)

273 The Greek *agape*, love and Latin *caritas*, charity will be used interchangeably in this thesis. The word *love* is open to a wide variety of usages in our modern world. It encompasses a complex set of experiences more or less interconnected, sometimes quite distinct, at other times variously overlapping. Generally love signifies a warm affection, attachment and devotion; it can refer to a desire for persons or things, such as love of books, love of attention or self love; it refers to the bond uniting people together or to certain objects or values, examples being physical sexuality, love of beauty or truth, or parental love; it can point to the more personal aspects of a relationship as in friendship or marital love; in moral discourse it often refers to benevolence or beneficence; in Christian ethics it means a supernatural virtue infused by God. Cf. N. Brown, *The Worth of Persons: A Study in Christian Ethics*, (Sydney: Catholic Institute of Sydney, 1983), 11

While there is no precise English equivalent translators frequently adopt four equivalents: *kindness* in references to a particular act of one person to another, *(deal) loyally* in reference to continuing behaviour of one person toward another, *steadfast love* or *love* in reference to God's consistent behaviour toward individuals in Israel, and *love*, *devotion, faithfulness,* or *loyalty* according to the context in reference to Israel's or a person's relation to God.[274]

In the Greek biblical texts four terms are most frequently used for the notion of love: *stergo* (affection founded on a natural bond such as a family relationship); *eros* (passionate, possessive love); *philia* (friendship; intimate, respectful, often tender love) and *agape* (preference, esteem). [275] In this context it is worth noting that terms from the *agape* family occur 341 times in the New Testament and are to be found in every book from Matthew to Revelation.[276]

It is the teaching of the New Testament that love (*agape*) is the principle of the moral life and even the substance of Christian revelation.[277] Jesus tells us that God is love.[278] This love is manifested in the way God has freely loved us even when we were sinners.[279] The best image of God's love is Christ himself.[280] Jesus' love is shown in his self-giving, particularly in the shedding of his own blood.[281] This is the sign of his love for sinners and it manifests his loving obedience to the Father.[282] Life for the Saviour is caught up in his selfless love for the Father and for sinners. The Christ-event revealed believers are destined to be one with him in the Mystical Body.[283] Now clothed with Christ in baptism the Christian must take on Christ's ways and mature to his stature even to saying, "it is no longer I who live, but Christ lives in me".[284] The moral life calls the Christian to reproduce the moral attitudes of

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[274] This taxonomy was developed by the Revised Standard Version of the bible. K. D. Sakenfeld, "Love (OT)" in *The Anchor Bible Dictionary*, edited by D. N. Freedman, Vol. 4, (New York: Doubleday, 1992), 376-378

[275] T. Barrosse, "Love (in the Bible)" in *New Catholic Encyclopedia*, Vol. 8, (New York: McGraw-Hill, 1967), 1043-44.

[276] W. Klassen, "Love (NT and Early Jewish Literature)" in *The Anchor Bible Dictionary*, edited by D. N. Freedman, Vol. 4, (New York: Doubleday, 1992), 381-96.

[277] Rom.13:10

[278] 1 Jn.4:8.16

[279] 1 Jn.4:10; Rom.5:8; Mt.5:45

[280] Jn.1:49

[281] Jn.15:13

[282] Jn.15:10

[283] Rom.12:4-5

[284] Gal.2:20; Eph.4:13-15

Christ himself. This is expressed in following Christ,[285] in loving God by keeping his commandments[286], in loving one's neighbour as Jesus loved us, even to death.[287] There is no greater commandment than that of love.[288] This love is the epitome of the entire Old Testament law and is a way more elevated than all the other gifts, the beginning of eternal life.[289] Love does not suppress other precepts but is the source from which they flow and is the bond of perfection.[290] Love is the new law since it is from within, natural to the believer as a new creature and so characteristic that Christians are to be recognised by it.[291] Others are to see in them, through this love, a continuing revelation of the unity of the divine persons and the presence of the Spirit of Christ.[292]

Explicit evidence of the link between charity and perfection is given by the most important patristic commentaries on Lk 10:25-38, Mt 25:31-46, 1 Cor 13 and the Song of Songs. For the Greek Fathers *agape* is superabundance: "the heavenly Father does not seek something more that could complete him, but wants to open his treasures. It is *philanthropia*, in the term preferrred by the Greek Fathers."[293]

Christian theology nourished by the teaching of the Bible, the Fathers of the Church and twenty centuries of theological reflection has understood charity to have the following basic structure:

> we are loved by God; we accept this love; we love God in response; we form a community with God; and we cooperate with God's love, which is directed to God, to ourselves, and to the rest of creation. In this endlessly evolving relation is found the inner unity of the two great love commandments. Because we share a love relation with God, we cooperate with the work that God's Spirit wants to achieve in and through us. This cooperation occurs within the church, but it extends beyond, especially to those who are poor and marginalized. In brief, charity is the life of grace.[294]

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285 Lk.9:23

286 Jn.14:15, 21

287 Jn.13:33-35; 15:12-13

288 Mt.22:37-38

289 Rom.13:8-9; Gal.5:14; 1 Cor.13:1-3

290 Eph.3:17-18; Col.3:12-14

291 Jn.13:34-35; 2 Cor.5:17

292 Jn.17:20-23; Cf. McCormick, *Health and Medicine in the Catholic Tradition*, 33-34; F. Prat, "Charité. I. La charité dans la bible" in *Dictionnaire de Spiritualité, Ascetique et Mystique*, Vol.2, (Paris: Beauchesne, 1953), 507-23.

293 T. Spidlik, "Love of God and Neighbour" in *Encyclopedia of the Early Church*, edited by A. Di Berardino, Vol. 1, (New York: Oxford University Press, 1992), 507

294 E. C. Vacek, "Charity" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville: The Liturgical Press, 1994), 143.

Christian love has selective aspects, but is also universal.[295] Preferential love may be appropriate but should never be exclusive. Love may be unilateral or mutual. In fact it is multi-directional: *downward* with a preference for the religiously and socially least valued, *laterally* toward equals and *upward* toward God. Christian love calls for patience when abuse is given, takes a stand against evil and promotes the good. Such love entails a willingness to sacrifice, yet it counts on a reward.[296] The complexity of love results in a situation where there is no known schema that adequately classifies all the objects we love or all the ways we love: we can speak of sensual, bodily, psychological, spiritual and religious loves. We distinguish some loves according to roles or activities as is the case in parental, spousal, or divine love. The tradition distinguishes between *agape* or charity and *eros, epithemia* and *philia*.[297] Two verses in St. John's first letter perhaps best describe the four most distinctive features of the Christian love ethic. It is (1) *theocentric* since the origin of genuine loving lies in God's gracious initiative, (2) *Christocentric* in that the Son is the focal point of the Father's love, (3) *active* and *self-sacrificial*, reaching its peak in the death of Christ, (4) demanding a *reciprocal, imitative response* from those who are its beneficiaries.[298]

While recognising the multi-dimensional characteristics of Christian love it is helpful here to focus on five qualities of love or charity.[299] First, love is perceived to be

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[295] Recent thinkers give greater significance to (1) the emotional dimension of love; cf. E. C. Vacek, "Love" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville: The Liturgical Press, 1994), 557; (2) psychological dimension of loving. Stephen Post defines love as "a disposition of the self that manifests in solicitude for the welfare of the other, and usually a delight in his or her presence." Post, "Love" in *Encyclopedia of Bioethics*, 1391

[296] Vacek, "Love" in *The New Dictionary of Catholic Social Thought*, 557

[297] 1 Jn.4:10-11. Another division of love suggested is (a) sensible and rational, (b) concupiscent and benevolent, (c) eros and agape, and (d) appreciative love (proposed by C.S. Lewis). This last seems to identify with the openness to being that is the root of all rational love. R. O. Johann, "Love" in *New Catholic Encyclopedia*, Vol. 8, (New York: McGraw-Hill, 1967), 1039-1040

[298] D. H. Field, "Love" in *New Dictionary of Christian Ethics and Pastoral Theology*, edited by D. J. Atkinson and D. H. Field, (Leicester: Inter-Varsity Press, 1995), 9

[299] The Catholic theological tradition contains a number of significant strands offering explanations of the virtue of Christian charity. Cf. L. B. Gillon, et al., "Charité. V. Les grandes écoles théologiques" in *Dictionnaire de Spiritualité, Ascetique et Mystique*, Vol. 2, (Paris: Beauchesne, 1953), 579-635. For a recent scholarly analysis of Aquinas's teaching on *caritas* see Keenan, *Goodness and Rightness in Thomas Aquinas's "Summa Theologiae"*. The Protestant theologian Anders Nygren in his *Agape and Eros*, published in the 1930s, emphasised the self-sacrificial dimension of *agape*. Gene Outka's *Agape* (1972) proposed an alternative to the earlier emphasis when he focused on *agape* as equal regard. Both these Protestant scholars significantly influenced theological analysis of Christian love in this century. Roman Catholic thinking has been influenced to some degree by their concerns and emphases. For more recent Roman Catholic approaches to *agape* see J. Cowburn, *Love and the Person: A Philosophical Theory and a Theological Essay*, (London: Geoffrey Chapman, 1967); E. C. Vacek, *Love, Human and Divine: The Heart of Christian Ethics*, (Washington, D.C.: Georgetown University Press, 1994)

universalist. The family and clan have been relativised by the New Testament. The parable of the Good Samaritan defined moral humanity in terms of responsiveness to strangers in need. In fact, biblical love is seditious where status is concerned. The roles of enemy, foreigner and the marginalised are recast. Love demands solidarity if people are to live in peace - solidarity with other humans, especially victims and outcasts, and with the earth.[300] Second, Christian love is *individualised*. Hannah Arendt once credited the bible with subverting the idea that the *polis* has priority. She argued that Christian belief in immortality changed the political sphere of symbols. Henceforth the individual is to be valued in a social context.[301] Third, Christian love is *action-oriented*. In the biblical understanding:

> love and justice are not opposites, but coordinates, manifestations of the same affect. Translating *sedaqah* as *justice* is something of a betrayal since *sedaqah* is suffused with merciful love. It is not a case of hard-faced justice versus the soft arms of love. The various words for justice and love in both the Hebrew and Greek Scriptures are linguistically interlocking. Both justice and love, in any language, are alternatives to egoism; both look to the private and public good; and both respond to need. So, just as one could not mistake justice for mere warm feelings, so in this literature, love is never without issue. It is a *doing* virtue.[302]

In the New Testament *agape* conveyed the sense of showing love through action. Justice in fact is part of love's link to action. The supreme delicacy of charity is to be found in recognition of the rights of the person who is the object of this love.[303] The fourth characteristic of Christian love is its *mystical* quality, for in love we affirm the unconditional significance of limited persons. Medieval thinkers used the notion of the *mystical* adopting its Greek root meaning, *to lie hidden*. What is mystical lies deep within the soul. The love that produces self-sacrifice and altruistic generosity has a profoundly mystical dimension the origins of which humans continually search to understand.[304] Finally, love has a *creative* dimension. In the Christian scheme of things it is possible to love because God has first loved us. In this understanding love begets love giving love a rebound effect.[305] Another aspect of love is its capacity to melt, what the medieval theologians designate *liquefactio*, thus making it a power

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300 Maguire, *The Moral Core of Judaism and Christianity*, 214-217

301 H. Arendt, *The Human Condition*, (Chicago: Chicago University Press, 1958), 314-315. This insight has been developed above in 7.2.1 in our study of the body and human bodiliness.

302 Maguire, *The Moral Core of Judaism and Christianity*, 220

303 P. Bigo, *La doctrine sociale de l'Eglise*, (Paris: Presses Universitaires de France, 1965), 378; cf. Maguire, *The Moral Core of Judaism and Christianity*, 223

304 Maguire, *The Moral Core of Judaism and Christianity*, 226-228

305 Aquinas uses the term *redamatio* to describe this aspect of love; cf. S.T.I-II,28,2c

that unites. It "promotes union through the melting of barriers. It does so without any loss of individuality.[306]

In spite of the extraordinarily rich theological analysis of charity in the Christian tradition there still remain a number of vigorously debated issues. Among the more significant might be noted differences of understanding (1) between love based on some perceived attribute in the other versus love based on value bestowed by the lover; (2) between love as acquisitive desire seeking the agent's good versus a benevolent love seeking the other's good; (3) the giving and receiving characteristic of friendship, marriage and other forms of companionate love raise the significance of the human desire for reciprocity; (4) the love for friends and family (special relations) must be balanced against love for the stranger (the so called *order of love* question); (5) the question about the nature of love that requires self-denial.[307]

In light of issues concerning intergenerational obligations and the care of the elderly raised earlier in chapter 5, two aspects of recent theological reflection on love must now be considered. First is the question as to how love and justice connect. In Christian ethics no single relationship between *agape* and justice dominates due to the wide variety of meanings attributed to both *agape* and justice. Recent scholarship has isolated four major conceptions of *agape* as love (1) that seeks the neighbour's welfare, or entails (2) self-sacrifice, (3) mutuality or (4) equal regard.[308] Justice has been viewed since the time of Aristotle as either synonymous with all of morality (in this sense justice is almost equivalent to righteousness) or is understood more narrowly as one standard among others for regulating institutions, practices, policies or actions. The latter, more narrow understanding of justice presumes some conflict about goods, otherwise the claims of justice, namely what is due to individuals or groups, is totally irrelevant. The main debates about justice concentrate primarily on the material criteria for identifying what is due to the other. A range of identifiable similarities and dissimilarities have been invoked such as needs (egalitarian theories), merit (meritarian theories), free actions, including contracts (libertarian theories) or social contribution (utilitarian theories).[309] Against this varied background Roman Catholic moral theory has always viewed love as completing but never contradicting the demands of justice.[310] In more recent times under the influence of liberation

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306 Maguire, *The Moral Core of Judaism and Christianity*, 230; Cf. S.T.I-II,28, a.1, a.5

307 Post, "Love" in *Encyclopedia of Bioethics*, 1391-1392

308 G. Outka, *Agape. An Ethical Analysis*, (New Haven: Yale University Press, 1972), 260-285

309 J. F. Childress, "Love and ...," in *Theology and Bioethics*, 228

310 Within Protestant theology there exists a range of positions on this question: love and justice are united - justice as the form of reuniting love (Paul Tillich); love and justice are identical (Joseph Fletcher); love and justice are in dualist association (Emil Brunner); love and justice are in a

theology this approach has been formulated in terms of a love that calls for the practice of justice.[311]

Second, the imperative to offer care to one's neighbour after the example of the Good Samaritan with the love of Christ has tended throughout Christian history to set an extremely high ideal for the followers of Jesus. His teaching is central to the Christian life: "I am giving you a new commandment: Love one another. As I have loved you, so you too must love one another."[312] How is this call to be meshed with the human experience of finiteness, personal limitation and sinfulness? In answering this question it is important to note the ambiguity of the phrase "as I have loved you". Christian teaching has always insisted that one must love "as Jesus loved". This, however, may indicate a number of things: (1) that *agape* is a formal principle of the Christian life; (2) that it refers to Jesus' understanding of what constitutes the welfare of others; (3) that the extent of his love is what is being demanded, namely one should be prepared to sacrifice one's life for the other; (4) that it concerns only the religious context of his love.[313] Raymond Brown, the eminent American Johannine scholar, has argued that "as I have loved you" emphasises that Jesus is the source of the Christian's love for one another. In this sense it is effective: "it brings about their salvation."[314] Only in a secondary sense does it refer to Jesus as the standard of Christian love. If this is the case it is still not clear how we can love one another *as* Jesus did in the first sense, so as "to bring about their salvation", unless it is that our loving faith is a channel for *his* love (saving grace) to others.[315] There is, however, a subsidiary sense where Jesus' love is understood in terms of absolute righteousness or purity of heart. It was a love shaped by the absoluteness and ultimacy of the God-relationship. The human goods that define human flourishing (life and health, mating and raising children, knowledge, friendship, enjoyment of the arts and play), while desirable and attractive in themselves, are subordinate to this structural God-relationship. A characteristic of the redeemed but still messy human condition is to make idols, to pursue these basic goods *as ends in themselves*. This is the radical theological meaning of secularisation. There occurs a loss of the context

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dialectical relation (Reinhold Niebuhr); love transforms justice (Paul Ramsey); love and justice as distinct but overlapping principles (Gene Outka).

311 This will be developed in greater detail below in chapter 8.3

312 Jn.13:34

313 Cf. MacNamara, *Faith and Ethics*, 149

314 R. E. Brown, *The Anchor Bible: The Gospel According to John*, Vol.2. (London: Geoffrey Chapman, 1971), 612-614; cf. R. Collins, "'A New Commandment I Give to You, That You Love One Another....'(Jn 13:34)" in *Christian Morality: Biblical Foundations*, (Notre Dame, Ind.: University of Notre Dame Press, 1986), 116-121

315 McCormick, *Health and Medicine in the Catholic Tradition*, 164, note 79

that effectively subordinates and relativises basic human goods in a way which prevents human beings from divinising them. "The goods are so attractive that our constant temptation (or our continuing enslavement, our bondage to the world, our constant need for liberation and deepening conversion) is to center our being on them as ultimate ends, to cling to them with our whole being."[316]

Jesus' love for humankind is primarily an empowering love. It is also, in its purity and righteousness, the standard against this type of idolatry. Whatever he willed for us and did for us, he did within the primacy and ultimacy of the relationship he had with God his Father. Since this relationship is at the centre of our human being and destiny, his love took the form of a constant reminder of this momentous dignity and is to people hell-bent on different forms of idolatry. Jesus' love, as standard, suggests the shape of our Christian love for each other. His conduct reminds others of their true dignity, being and destiny, and therefore supports and protects the status of basic human goods as subordinate. In this sense it is possible to say that Jesus is the norm above all of human self-perception, of what human beings are called to in a new way. Accordingly, following or imitating Christ means, in a negative sense, never pursuing human goods as *final ends* and, positively, entails pursuing them *as subordinate* ends.[317]

This study of love in the Christian tradition has drawn together some of the key elements upon which a theology of health care may now be developed. This necessitates an analysis of care-as-love in its corporate and individual manifestations. In what follows attention will be given to a theology of health care in general and to Catholic identity in health care in particular. Within this context it is possible, then, to explore the characteristics of *agapeic* care revealed in the Christian who lives both as a good person and as a committed health care professional.

7.3.4 A Theology of Health Care

From the Christian point of view, the field of health care is a privileged context in which to encounter another person and hence to encounter Christ.[318] The Catholic health care institution, as the extension of a particular religious and moral

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[316] McCormick, *Health and Medicine in the Catholic Tradition*, 37

[317] "[T]hose who strive to follow him ('as I have loved you') are performing the profoundest act of love for the world by pursuing in interpersonal life the basic goods *within their context* and *as subordinate*. In this sense, both Christ's love for us as standard and our love for each other constitute a profound relativizing of basic human values." McCormick, *Health and Medicine in the Catholic Tradition*, 38

[318] McCormick, *Health and Medicine in the Catholic Tradition*, 39

community, is committed to providing compassionate support directed to the welfare, well-being and integrity of the patient.[319] In the Christian hospital governed by this ideal the patient is welcomed unreservedly as a pilgrim on life's journey. This welcome is extended by those who themselves are also pilgrims on the same journey. The Catholic hospital endeavours to be a special kind of community centred on the mystery of the eucharist, the sign of Christ's ongoing service to all. The hospital's identity comes from the Risen Lord, present through his ministers. It is the place *par excellence* where the security and interest of the patient are paramount.[320] Significant changes are taking place in Catholic health care at the present time. The import of these changes will be seen more sharply if the theological foundations of this health care are first laid out.

The view of health care in the Catholic tradition is shaped by a number of assumptions about what it means to be Church. This theological foundation has been articulated in terms of *models of the Church.*[321] In this schema the Church is viewed as (1) institution, (2) communion, (3) sacrament, (4) herald and (5) servant.[322] Church as *institution* focuses on the Church as a perfect society having a particular structure and government. Particular emphasis is given in this model to the rights and powers of those having authority in the Church. The health apostolate viewed with institutional glasses is Catholic to the extent that it has the blessing of ecclesiastical authority and to the degree it remains faithful to authoritative instructions. For the Church as *communion* emphasis is placed on the people of God who form a communion or *koinonia.* Authority in this model aims to unite, to establish communion, to elicit from the charismatic community the insights of each of the faithful, to stir their love for the community and to elicit their missionary concern. For the health care environment the special strength of this model is the practice of coresponsibility. Pressures arising from lack of time and insufficient preparation of personnel to work at communal discernment place difficulties in the way to implementing this approach to health care. The notion of Church as *sacrament* was clearly articulated by the Second Vatican Council. Because of the Church's

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319 Catholic Bishops of N.S.W., *The Ministry of Healthcare in the Catholic Church*, (Sydney: privately published, 1989), 13

320 Catholic Bishops of N.S.W. *The Ministry of Healthcare*, 16; see also U.S. Bishops. "Ethical and Religious Directives...," *Origins*, 452-453

321 A. Dulles, *Models of the Church*, (New York: Doubleday, 1974)

322 W. J. Burghardt, "Models of Church, Models of Health Apostolate", *Hospital Progress* 62 (1981): 22-29. This article is the most developed systematic theological reflection on health care published in English. Other published material has a wider focus, e.g. Casey, *Food for the Journey*, 31-41 or builds a theology of health care primarily in biblical terms, e.g. R. A. Brungs, "Toward a Theology of Health Care", *Review for Religious* 45 (1986): 24-44.

"relationship with Christ, the Church is a kind of sacrament or sign of intimate union with God, and of the unity of all mankind."[323] The health care community, by extension, is also a sacrament of Christ continuing his work of healing. This particular understanding demands that a living spirituality be at the centre of the healing ministry. Both work and prayer must speak of the profound conviction that all that is done in the health care setting is to be an effective sign of total healing for the sick person. The Church's mission is to proclaim the Word of God to the whole world, that is it called to be a *herald.* In health care the language, conversation, information giving and any other form of communication conveyed to the sick person is an integral part of the ministry of proclaiming the good news of Jesus Christ. The fifth model of Church influencing Catholic health care takes a different direction to the preceding four. Implicit in each of the preceding models the Church is understood as an active subject influencing the world in which it exists. As a consequence of Vatican II's recognition of the autonomy of human culture and science the Church has come to view itself as very much part of the human family. This has brought about a focus on an understanding of Church as *servant*. The focus here is outward to the world and is shaped by the model of Christ the Suffering Servant.[324] All five models have direct implications for the style of health care offered within the Catholic health care setting and contribute to the development of a profound and richly textured theology of health care. It is not simply an abstract theology but a spiritual way of life. In an address to Catholic health care providers, the eminent American theologian Walter Burghardt paints a very high ideal for health care: "Here your service, by word and gesture, within an institution that is an interpersonal community, is a splendid sacrament of Christ, a striking sign that God is here, a ceaseless service to men and women working out their redemption through crucifixion."[325]

Reference has already been made to the changes occurring at present in Australian Catholic health care, of which five aspects are worth noting. First, the character of

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[323] *Lumen gentium*, n.1 in Flannery, *Vatican Council II*, 350

[324] Burghardt offers a word of caution about this model: "Christian service - especially if taken as model of Church and health apostolate - may not be interpreted to mean that our function is to establish the kingdom of God on earth, that our task is primarily to wipe out poverty and injustice, to find a cure for every human ailment, to push back death and the causes of death. Neither the Church nor The Catholic Health Association is simply a humanitarian agency; it is a sacrament of salvation. In the last analysis, a living/dying person must be healed, and to heal is to make whole even where the flesh is weary unto death. To be healed is to be reconciled: with the earth, with myself, with my brothers and sisters, with God. To be healed, to be made one, we must suffer together, hand in hand with Christ; in him we are all suffering servants" Burghardt, "Models of Church...," *Hospital Progress*, 28

[325] Burghardt, "Models of Church...," *Hospital Progress*, 29

health care delivery is changing dramatically in the wider society. Health care is being transformed from a social good to being a commodity subject to market forces like any other product. Second, health care is increasingly being linked to an individual's ability to pay (either through the Medicare levy or by subscription to private health insurance). The renewal of religious life following Vatican Council II and a diminishing number of vocations to religious life are affecting the ability of religious communities to staff health care institutions. Finally, the emergence of lay ministries since the Second Vatican Council has contributed to a considerable unevenness in Catholic involvement in health care. The formation of lay Catholics to equip them to fulfill tasks previously held by religious men and women is still in its infancy.[326]

In this context of changes in health care in Australia the Catholic bishops of New South Wales have warned that unless a Catholic hospital gets its vitality from its own religious faith and system of values it will become more hurtful than healing and a scandal rather than a witness to Christ's presence in a suffering world.[327] A similar warning could be offered to state-run secular hospitals. Without a commitment to humanist ideals a secular hospital becomes a depersonalised machine which hurts as much as it heals.

Here the Catholic bishops are in full accord with the *Decree on the Lay Apostolate* of the Second Vatican Council which provided a rationale for Catholic health care where leadership and services are more than ever being provided by professional lay men and women. Christ made the commandment of love his own and endowed it with new meaning for he wanted to identify himself with his brethren as the object of this love when he said, "as long as you did it for one of these, the least of my brethren, you did it for me".[328] But if this profound structure of the health care encounter is to be lived, certain fundamentals must be observed. Thus attention is to be paid to the image of God in which our neighbour has been created, and also to Christ the Lord to whom is really offered whatever is given to a needy person.[329] If the health care encounter is viewed and lived in this way it will be both guided by and generative of the moral dispositions and perspectives implied in Christ's phrase "as I have loved you". The profound ontological structure of the encounter, "fully disclosed in and by Christ, a structure we perceive only dimly (in faith), but one that

[326] Cf. L. J. O'Connell, "The Future of the Catholic Healthcare Institutions", *Chicago Studies* 27:3 (1988): 288-292

[327] Catholic Bishops of N.S.W., *The Ministry of Healthcare*, 19

[328] Mt.25:40

[329] Cf. *Apostolicam actuositatem*, n.8 in Flannery, *Vatican Council II*, 775-76

ought to be the organizing shape and power of our responses" is at the centre of the health care ministry.[330] This is what the Decree on Laity meant when it urged professional people to remember that in fulfilling their secular duties of daily life "they do not separate their union with Christ from their ordinary life." It further urged professionals to "see Christ in all men, acquaintance or stranger."[331]

If health care personnel view their profession in this way three important results will follow. First, there will be growth in dispositions that nourish, protect, and support the medical encounter as a truly human (not merely technological) one, particularly the virtues of compassion, honesty, self-denial, and generosity. Second, it is not unreal to expect that persons with such faith and dispositions will, in time, progressively transform the health care profession. The *Decree on the Apostolate of Lay People* states of persons of faith that "their conduct makes itself gradually felt in the surroundings where they live and work."[332] This transforming of the temporal sphere is especially important when advancing technology and growing impersonality are dominating health care. Christian living is called by Jesus to be a *leaven* in the world. Third, the "penetrating and perfecting of the temporal sphere" is guided by the phrase "as I have loved you". The ultimacy and absoluteness of the God-relationship and the corresponding relativising of other human goods has its influence in health care delivery where there is a temptation to abandon dying patients or to view death as defeat.[333]

The perspectives just outlined indicate the importance of a vision and spirituality for health care personnel. Spirituality refers to both the personal and corporate life environment. This fosters and deepens belief and insight into the basic structure of human lives as revealed in God's self-disclosure in Jesus and in the way this is encountered in the medical context. If such a spirituality is not developed a gap will exist between personal belief and professional life.[334] The danger is that should health care cease to be a personal apostolate it will become a job. When that happens, patients are in danger of becoming depersonalised objects. All Catholic literature on health care gives central importance to the person of the patient. The primacy of the patient is to be maintained in two ways. First Catholic policy continues to subscribe

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[330] McCormick, *Health and Medicine in the Catholic Tradition*, 40

[331] *Apostolicam actuositatem*, n.4 in Flannery, *Vatican Council II*, 770

[332] *Apostolicam actuositatem*, n.13 in Flannery, *Vatican Council II*, 781

[333] "Only the light of faith and meditation on the Word of God can enable us to...make sound judgments on the true meaning and value of temporal realities both in themselves and in relation to man's end." *Apostolicam actuositatem*, n.4 in Flannery, *Vatican Council II*, 770

[334] Cf. McCormick, *Health and Medicine in the Catholic Tradition*, 41

to the view that, although high-technology care is important, the low-technology model of health care remains relevant. This point was succinctly made in a speech prepared by the late Andre Hellegers, founder of the Kennedy Institute at Georgetown University, Washington, D.C., but never delivered because of his sudden death:

> As the caring branches of medicine were gradually pushed aside by the curing ones, there seemed to be less use for the Christian virtues. I think that shortly the need for those old Christian virtues will return and once again be at a premium. Our patients will need a helping hand and not a helping knife. This is no time to dismantle the low-technology care model of medicine . . . We must either recapture the Christian virtues of care or we shall be screaming to be induced into death to reach the 'discomfort free society'.[335]

Second, Catholic hospital policy subscribes to the biblical notion of covenant which obliges the more powerful to accept some responsibility for those who are vulnerable and powerless. Self-interest must not hold sway subject only to the capacity of the weaker partner to protect himself or herself through knowledge, shrewdness or purchasing power. God joins himself to the needy and makes their cause his own.[336]

Serious commentators on Catholic health care today have argued that the changing context of health care delivery in developed countries is becoming incompatible with the culture of Catholic health care ministry. The American Jesuit moralist, Richard McCormick, has noted somewhat pessimistically that changed circumstances in the U.S.A. have "weakened and sometimes dissolved the culture of the Catholic health care facility, the strength and transforming power of its vision."[337]

It must be acknowledged before going any further that no one, fixed and static view of Catholic identity dominates all health care facilities. Rather the search for identity is an ongoing process and is often, perhaps always, occasioned by crises. From the viewpoint of the Church's canon law there are three ways by which a health care facility can be regarded at law as *Catholic*.[338] First, Catholic identity may be

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335 Quoted in McCormick, *Health and Medicine in the Catholic Tradition*, 41 from an unpublished manuscript.

336 Cf. May, *The Physician's Covenant*, 124

337 R. A. McCormick, "The Catholic Hospital Today: Mission Impossible?", *Origins*, 24:39 (1995): 648. McCormick's colleague James Keenan argues that "the primary task for Catholic health-care facilities as they face a future maintaining moral and medical competency and Catholic identity should be to establish programs through which their members acquire and exercise the virtue of prudence. It will have to be the virtue of its members, after all, that guides the Catholic health-care facilities to right conduct." J.F. Keenan, "Moral Horizons in Health Care: Reproductive Technologies and Catholic Identity" in *Infertility. A Crossroad of Faith, Medicine and Technology*, edited by K. Wm. Wildes, (Dordrecht: Kluwer Academic Publishers, 1996), 68

338 F. G. Morrisey, "What Makes an Institution 'Catholic'?", *The Jurist* 47 (1987): 536-37

expressed in the excellence or quality of care given to each person. Second, Catholic identity may be linked in a essential way to the quality of the health care workers employed and to respect shown for the institution's mission, philosophy and code of ethics. Third, the responsibility for maintaining and strengthening this identity rests primarily with the health care facility itself and, while it is primarily entrusted to leadership personnel, it is shared by all involved in the facility.[339]

As a public institution or organisation four characteristics delineate a Catholic hospital or nursing home: (1) it operates under the direction of the bishop of the diocese in which it operates; (2) it is sponsored by a religious community, lay organisation or diocese; (3) a priest chaplain functions within the pastoral care team, celebrating eucharist regularly and providing the sacraments and pastoral care to patients and staff; (4) the buildings are marked by religious symbols such as statues, crucifixes, and the religous garb of religious personnel.[340]

To justify its separate existence in a pluralistic society the Catholic hospital must satisfy three areas of responsibility. It must provide scientific medical care, be administered with persons as its focus and must, at the same time, be socially conscious. In all three areas it must at least equal the secular hospital. To justify itself as a Catholic and Christian hospital, it must in addition illuminate all with charity and be a witness to the gospel. There is no alternative if the Catholic hospital is to preserve its special character and provide what the public and secular hospital cannot.[341]

In the Australian context Francis Sullivan, the Executive Director of the Australian Catholic Health Care Association, has proposed six steps for ensuring the continuing Catholic identity of health care in this country. Each proposal points to a difficulty current in Australian Catholic health care. First, the context and realities shaping health care delivery today must be seen as avenues through which contemporary ministry and hope can be conveyed. Second, there is a need for a Catholic strategy integrating health, welfare, education and parish structures and resources. Together

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[339] R. J. Austin, "The Ministry of Catholic Healthcare: A Church Law Reflection on its Future", *Australasian Catholic Record* 73:2 (1996): 166-167. The issue of Catholic identity has been much discussed principally in the area of Catholic education. Publication of John Paul II's Apostolic Constitution, *Ex corde ecclesiae*, (August 15, 1990) gave momentum to the discussion. The rationale applied by the pope to Catholic education is now being used in the examination of Catholic identity in health care.

[340] Ashley and O'Rourke, *Health Care Ethics*, 136

[341] Cf. E. D. Pellegrino, "What Makes a Hospital Catholic?", *Hospital Progress* (1966): 70; See also Ashley and O'Rourke, *Health Care Ethics*, 137

these have the potential to collaborate and assist in the realisation of commonly held goals. Third, Catholic health care must seek to place access to services as its strongest contribution to the general good of the community. This results in a recognition of the social contribution and responsibility of not-for-profit health care. Fourth, a comprehensive and professional approach to the development and on-going formation of leaders in Catholic facilities is crucial. The theological and spiritual formation of personnel will have an influence on many of the structural difficulties at present affecting Catholic health care. Fifth, engendering a collaborative process of planning and cooperation between present religious bodies sponsoring health care facilities will ensure they will adapt and remain viable. Sixth, credible and positive contributions to public health care issues and debates will ensure a significant Catholic presence into the future.[342] These six dimensions pose challenges for an identifiable Catholic health care involvement in Australia: an ongoing commitment by the Church to this area of care; cooperation and planning within the Church at large; provision of services to all in need by Catholic health care viewed as charitable institution; formation of personnel and cooperation between different Catholic health care systems; credible and effective contribution to public policy development at state and federal government levels.

7.3.5 The Virtuous Health Care Professional

The concern with Catholic identity in health care delivery places great importance on individual and organisational qualities that express the central convictions of Catholic Christianity. As Catholic health care increasingly becomes the responsibility of professional lay men and women it is relevant here to explore the characteristices of the virtuous health care professional who offers healing and care to the sick, frail and vulnerable in society. Today people directly involved in human healing are called *professionals*. From the Middle Ages divinity (theology), physic (medicine) and law were viewed as the person-focused professions. They did not produce goods for sale or works of art for enjoyment but worked to heal, guide or protect persons in life crises. It is claimed that industrial society has greatly fostered professions in civic life but in the process has depersonalised them. They are no longer concerned with interpersonal communication but focus on outcomes. In post-industrial society where knowledge and its communication give power there is an ever greater need for the professions. For that reason, it is argued, the professions must be reconstructed to

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[342] F. Sullivan, "Dreaming the Impossible Dream", *Australasian Catholic Record* 73:2 (1996): 134-135; see also E. D. Pellegrino, "The Catholic Hospital: Options for Survival", *Hospital Progress* 56:2 (1975): 42-52.

eliminate the three-fold depersonalisation that they have suffered in modern times. First, clients have been depersonalised by an ever increasing specialisation where the notion of healing as "making whole" has been lost. Second, professionals themselves have been depersonalised by the loss of a clear identity amidst a multiplicity of roles in modern society. The composition of health care teams in geriatric assessment and care exemplifies this development. Third, the professional-client relationship is also being questioned since professionalism is seen to imply an elitism that is destructive.[343]

In the strict sense a profession aims at providing a service directly to individuals. The latter are not mere passive recipients but cooperate in what the professional is able to facilitate on their behalf. In health care the aim is to heal patients, to make them whole, to free them to act on their own. Thus, a profession cannot be elitist since it communicates power rather than enforcing dependency. Professional help in the full sense is concerned with problems that are deeply personal, even matters of life and death. Therefore, such help engages the professional and client in a profound responsibility both to each other and to the community.[344] The Christian medical profession finds a model in Christ, the healer. They imitate Jesus' compassion for the suffering and ill person and his reaching out to the most neglected, even lepers. This Christian attitude cannot be a matter of mere pious words. Rather, it expresses a profound dependence on God who gives the health care professional the inspiration, insight and courage to carry out his or her work as professionally and as skillfully as possible.[345] This entails respect for scientifically established medical facts but is not limited to them alone. There must also be an openness to all humanistic approaches that contribute to understanding and evaluating the human condition.[346]

The eminent American, Edmund Pellegrino, is an exemplar of the true medical professional and the committed Catholic layman.[347] A brief consideration of this

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[343] Ivan Illich has criticised professions for being production funnels that result in the proliferation of subordinate professions and paraprofessions. He has argued that people be freed from this social structure and that non-specialists should have easier access to the information now the prerogative of professional elites. Cf. Ashley and O'Rourke, *Health Care Ethics*, 76-80

[344] Ashley and O'Rourke, *Health Care Ethics*, 80

[345] T. E. Clarke, "Touching in Power: Our Health System" in *Above Every Name. The Lordship of Christ and Social Systems*, edited by T. E. Clarke, (Ramsey, N.J.: Paulist Press, 1980), 252-260

[346] Ashley and O'Rourke, *Health Care Ethics*, 87-88

[347] Robert Veatch considers that the creativity of Pellegrino's work is to be found in the fact that he is a man knowledgeable about and committed to three different ethical traditions: Aristotelian thought, the tradition of professional ethics and the moral theology of the Catholic Church. Cf. R. M. Veatch, "Justice in Health Care: The Contribution of Edmund Pellegrino", *The Journal of Medicine and Philosophy*, 15 (1990): 283

prolific author permits a link to be made between the consideration of philanthropy and beneficence in chapter 3 with the role of charity in the life of a Catholic who is a medical professional.[348] Pellegrino, at times writing with the philosopher David Thomasma, has built his thinking on the nature of the doctor-patient relationship. He has argued that medicine is an integral discipline in its own right. There is a philosophy of medicine which is based on an identifiable human activity.[349] Medicine is neither science nor art, but a *techne iatrike*, a practical discipline of healing.[350] Medicine teaches us about human existence because it deals both with the fundamental aspiration of the human person to be healthy and the reality of tragedy in human living. The values of both the professional and the patient in the medical encounter are grounded in meaning that human existence has for both participants.[351] The healing relationship thus involves three essentially related features.[352] First, the healing relationship is distinguished by the vulnerability of the ill person. Pellegrino describes the experience of illness as an *ontological assault*.[353] It brings with it a sense of disruption, anxiety, uncertainty and often fear and pain. This forces the sick person to place himself or herself under the power of another - the doctor. In order to achieve change the patient must reveal his or her body, personal life and history to the doctor. This gives rise to what Pellegrino calls *the act of profession*. This is a declaration that the doctor is willing to offer his or her services, that he has special knowledge or skills and that he can heal or help and will do so in the patient's interest. The relationship between the ill person and the doctor is thus one of inequality. Because of the doctor's public *profession* a context of trust is established that gives a particular character to the doctor-patient relationship. The *the act of medicine* constitutes the third element of the doctor-patient encounter.[354] This is built on the diagnostic (what is wrong?) and the prognostic (what can be done?) questions which constitute "a right and good healing action taken in the interests of a particular patient."

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348 Pellegrino views charity as the perfection of philanthropy. Cf. E. D. Pellegrino, "Christian Charity: The Perfection of Philanthropy", *Social Thought* 7:3 (1981): 15-21.

349 "*Medicine as a disciplined body of knowledge is a science respecting the perfection of lived bodies concretized by skill in experiencing and effecting connections between corporeal symptoms and remedies*"[authors' emphasis], in E. D. Pellegrino and D. C. Thomasma. *A Philosophical Basis of Medical Practice. Toward a Philosophy and Ethic of the Healing Professions*, (New York: Oxford University Press, 1981), 80-81

350 D. C. Thomasma, "Establishing the Moral Basis of Medicine: Edmund D. Pellegrino's Philosophy of Medicine", *The Journal of Medicine and Philosophy* 15 (1990): 248

351 Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice*, xiv

352 E. D. Pellegrino, "Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness", *The Journal of Medicine and Philosophy* 4:1 (1979): 32-56.

353 Pellegrino, "Toward a Reconstruction...," *The Journal of Medicine and Philosophy*, 44

Three dimensions of Pellegrino's philosophy of medicine are significant for an understanding of his approach: his teleological framework, the fiduciary character of the doctor-patient relationship and the way the relationship makes demands on the virtuous doctor. First, Pellegrino adopts an Aristotelian teleological framework. The *telos* of the clinical encounter is not health *per se* as an ideal of bodily function but rather the good of the one who is ill. Once the patient's good is identified as the proper end of clinical activity, the specific goals of the doctor-patient relationship can incorporate elements beyond restoration of health when this is not a forseeable outcome - the relief of pain and suffering, development of adaptive or coping mechanisms in the case of chronic or fatal illness. Cure, palliation, adaptive living are all forms of care that serve the patient's good.[355]

Second, Pellegrino gives priority to the principle of *beneficence-in-trust* thus emphasising the fiduciary character of the doctor-patient relationship. "By beneficence-in-trust we mean that physicians and patients hold 'in trust' (Latin, *fiducia)* the goal of acting in the best interests of one another in the relationship."[356] In this he rejects the prevailing liberal understanding that acting beneficently is paternalistic for in doing so this effectively usurps the patient's liberty. Pellegrino avoids this *either/or* by focusing on four aspects of the patient's good designating (1) the ultimate good as the patient understands it, (2) the good of the patient as a human being: ability to reason, choose and have a life-plan, (3) the good as perceived by the patient, that is the patient's subjective assessment of his or her quality of life given the circumstances and the medical options available, (4) the medical good that can be achieved by particular clinical interventions into the natural history of the patient's disease or injury.[357] The last element constitutes the *medically indicated course of treatment*. Pellegrino interprets the patient's good in a way that the concept of benefit or beneficence is necessarily inclusive of more than mere *medical* benefit. The principle of beneficence can be said, within the healing relationship, to have an ontological priority over the principle of autonomy. This ontological priority is conveyed by Pellegrino's use of *fiduciary beneficence* or *beneficence-in-trust*. The

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354 Pellegrino, "Toward a Reconstruction...," *The Journal of Medicine and Philosophy*, 47

355 E. D. Pellegrino, "The Healing Relationship: The Architectonics of Clinical Medicine" in *The Clinical Encounter. The Moral Fabric of the Patient-Physician Relationship*. Philosophy and Medicine ed., edited by E. Shelp, Vol. 4, (Dordrecht: Kluwer Academic Publishers, 1983), 163

356 E. D. Pellegrino and D. C. Thomasma, *For the Patient's Good. The Restoration of Beneficence in Health Care*, (New York: Oxford University Press, 1988), 55; for a collection of articles analysing beneficence-in-trust see E. D. Pellegrino, R. M. Veatch and J. P. Langan, eds., *Ethics, Trust, and The Professions. Philosophical and Cultural Aspects*, (Washington, D.C.: Georgetown University Press, 1991)

357 Pellegrino and Thomasma, *For the Patient's Good*, 76-83

dialogue between doctor and patient becomes the centrepiece of the beneficence-in-trust model.

An understanding of the virtuous doctor is integral to Pellegrino's approach. Because doing the right thing entails promoting the patient's good there is required on the part of the doctor a degree of personal discretion. In fact, the doctor's good character is the best assurance that the right thing will be done. Such practice of medicine cannot be sustained, however, without institutions. The problem here is that the goods internal to medicine can be compromised by institutional goods or goals that are themselves external to the practice of medicine. Economic policies that place the doctor in a *gatekeeper* role may be inimical to the patient's good and thus threaten the good internal to the practice of medicine. This highlights the role of the virtuous doctor in such situations.[358]

The preceding exposition of Edmund Pellegrino's understanding of medicine locates the notion of the good, commitment to persons within a covenant framework and the personal integrity of the virtuous doctor at the centre of medicine as the work of the virtuous professional. This particular view fits harmoniously with the theology of health care portrayed above.

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[358] Pellegrino and Thomasma, *For the Patient's Good*, 111-124. The author complements this with a consideration of the virtues of the good patient (*ibid.*, pp.99-110). Pellegrino is not without his critics. His colleague David Thomasma, in a perceptive analysis of Pellegrino's philosophy of medicine, indicates a number of weaknesses: (1) Pellegrino's traditional notion of the doctor-patient relationship takes little account of recent developments emphasising patient autonomy and decision-making; (2) exclusive focus on the doctor-patient relationship neglects third-parties in health care such as the role of administrators, insurance providers and the government; (3) he has an unduly individualistic notion of medical practice which ignores the social reality of medicine and focuses primarily on the individual and his or her disease; (4) Pellegrino fails to adequately clarify the connection betwen the individual and the common good; (5) he needs to articulate a negotiation model where the four goods of the patient are in tension. D. C. Thomasma, "Establishing the Moral Basis of Medicine: Edmund D. Pellegrino's Philosophy of Medicine", *The Journal of Medicine and Philosophy* 15 (1990): 254-259. Robert Veatch, in his critical analysis of Pellegrino's work, observes that "in Catholic Christian ethics the Christian theological virtues are added to the Greek. What is known by revelation is added to what is known by reason. It is little wonder that a social teleology will be added to the patient-centered teleology of the Hippocratic tradition. This harmony may come at a great price, however. It may come at the price of overlooking the real, insurmountable tensions among these traditions." R. M. Veatch, "Justice in Health Care: The Contribution of Edmund Pellegrino", *The Journal of Medicine and Philosophy* 15 (1990): 284

7.4 SUMMARY AND CONCLUSIONS

7.4.1 Summary

Chapter 7 has argued that the values of Roman Catholic moral theory *frame* the humanistic, socially constructed understandings of aging, well-being and care already discussed in chapter 2. A transformation of our human understanding of them occurs when this *frame* is in place. I have argued that aging must be framed by understandings of *human life* and *death*, that well-being must be framed by understandings of the *human body and bodily existence* and by the realities of *pain and suffering*, and that care must be framed by an understanding of Christian *agape* or charity. The latter transforms human care at the level of personal *motivation* and personal *performance*.

7.4.2 Conclusions

Chapter 7 has reworked from a theological perspective the three problematic questions discussed earlier in chapter 2. This elaboration permits me to draw the following conclusions.

Regarding aging:

1. A theological understanding of aging has as its context the wider theological framework of human life and death. It integrates aging into the whole of one's life and enriches aspects of aging by placing the experience of growing old within the individual's unique story and that of the community.

    - The Christian moral vision which values life and is conscious of death directly influences behaviour and life expectations.

    - The notion of aging requires a total life-span view. Catholic moral theory has emphasised each person's responsibility to live fully at every stage of life and to see each phase as directly preparing for the stages to come. Ultimately life is a preparation for final union with God. This implies that any social segmentation that isolates any age group from the total community is detrimental to the life of the community. One effect is to depreciate old age. It deprives younger generations of seeing their present life as directly linked to and preparatory for their later years. This

perspective suggests that health care for aged persons must be immersed in multi-generational community living.

2. Time, dependence, poverty and leisure are elements contributing to a theology of aging. The ways in which these notions have been enriched in the theological reading of aging has been demonstrated. Nevertheless, I argue that they may be appropriated by people who do not accept the basic tenets of Christianity. A secular, non-religious understanding of the role of *time* as contributing to three dimensional human existence, the experience of *dependence* that acknowledges interdependence and solidarity, the understanding of *poverty* as the experience of being both creature and limited, and *leisure* experienced for spiritual, cultural and civic pursuits are positive contributions Catholic moral theory can offer to public discussion, policy development and health care delivery for aged Australians. These four elements provide criteria for ethically and theologically evaluating the justice and quality of health care offered to the aged.

Regarding well-being:

1. Human embodiment constitutes an important arena for assessing the issues of justice, health care and aging. In a society deeply attached to bodily beauty and the capacity to function effectively, human bodiliness is frequently viewed as an instrumental value. I argue that a theological perspective recognises that an aging person's body is the privileged *locus* of care and attention. This is recognised no matter how limited, handicapped, disfigured or decrepit a particular person's body may be. In Catholic thinking the body of the elderly person is sacramental, open to revealing mystery, especially the mystery of God.

2. Approaches to health and illness, particularly in the lives of aged persons, must adopt a wholistic understanding of health and illness, well-being and healing. The realm of the spirit is integral to this understanding. Such an emphasis enables the individual to confront his or her pain and suffering without in any way ever adequately explaining it.

Regarding *agape* as Christian care:

1. A Christian understanding of charity goes beyond the elements of care sketched in chapter 2.3. Caring entails not only practical solicitude for the needs of the neighbour but also a degree of personal commitment on the part of the carer that arises from interior dispositions of mind and heart.

2. *Agape* as the core of Christian care encompasses more than beneficence, philanthropy or altruism. It avoids any suggestion that care is that which occurs only between a giver and a receiver, from a greater to a lesser individual, from an expert to a lay person. Likewise in the notion of Christian care there is no suggestion that care may be solely unilateral or narrowed contractually to designated participants. Rather Christian love locates care for others within the covenantal fidelity of God to human beings made concrete in his incarnate Son. An *agapeic* care is essentially the giving of what one has first received from God and receiving from the neighbour what God has first given to him or her. Christian care is thus a concrete expression of the relational morality outlined in chapter 6.

3. The view that portrays health care as a commodity or gives undue emphasis to technical expertise and skill overlooks an essential requirement for health care for the aged. Such care must be offered to aged persons by individuals who have a personal commitment and interior dispositions that shape their service of the elderly person. Without in any way diminishing the place of competence and professionalism in health care for the aged I argue that an understanding of *agape* as Christian care implies a particular quality of care, one that gives priority to interpersonal relations, to the mutual interchange of equals in a community where care has a higher priority than efficiency, achievement or outcomes.

The Catholic health care system, to the degree it implements the tradition of *agapeic* care, can contribute to wider public reflection and to the development of policies in health care delivery. As a significant contributor to health care provision in this country, particularly in the area of aged care, the principles and priorities of this health care system have something significant to offer to the wider Australian community. This is a concrete expression of the Church's social mission outlined earlier in chapter 6.3.3

CHAPTER 8

JUST HEALTH CARE FOR THE AGED: THREE CONCEPTS

8.1 The Human Person 406

- 8.1.1. The Notion 406
- 8.1.2 The Human Person in Contemporary Systematic Theology 408
  - 8.1.2.1 The Human Person in Catholic Social Justice Teaching 409
  - 8.1.2.2 The Person and Trinitarian Theology 412
  - 8.1.2.3 The Human Person in Creation Theology 416
- 8.1.3 The Human Person in Contemporary Moral Theory 419

8.2 The Common Good 422

- 8.2.1 The Notion 422
- 8.2.2 The Common Good in the Tradition 423
- 8.2.3 Catholic Thinking on the Common Good in the Twentieth Century 429

8.3 Justice as Preferential Option for the Poor 436

- 8.3.1 Justice 438
- 8.3.2 Toward a Theology of Justice 446
- 8.3.3 The Preferential Option for the Poor 449
- 8.3.4 Just Health Care Delivery 455

8.4 Summary and Conclusions 458

- 8.4.1 Summary 458
- 8.4.2 Conclusions 459

CHAPTER 8

JUST HEALTH CARE FOR THE AGED: THREE CONCEPTS

In Chapter 7 the problematic issues discussed earlier in chapter 2 were developed in a number of significant ways through a theologically derived frame-of-reference that built on and enriched the earlier humanistic discussion. This chapter makes the general discussion of aging, well-being and care just completed even more precise by discussing three key concepts in Roman Catholic theology. The notions of the *human person*, the *common good* and *justice as preferential option for the poor* are the three concepts essential for an adequate theological analysis of the two justice questions to be considered in the next chapter. Chapters 7 and 8 thus provide the elements of Roman Catholic moral theory that enable me to address the justice issues that are the focus of Part III of this study.

Chapter 8 thus builds on the insights of the previous chapter and these two chapters together provide the substantive general ethical theory of the theological inquiry (Part III) that parallels the bioethical exposition of Daniels and Callahan in chapter 4 (Part II). Chapter 8 consists of three sections. Each section studies a vast area of theological inquiry which could hardly be considered adequately even if studied in a separate monograph. For that reason chapter 8 seeks only to present historical and theological detail sufficient to support the argument of this thesis in its analysis of the two concrete limits situations in chapter 9.

In the first section, on the human person, four strands of reflection are brought together from Catholic social justice teaching, trinitarian, creation and moral theologies. Section two analyses the idea of the common good and builds on the previous consideration of the human person, attending to the social conditions that are judged vital for enhancing human dignity and ensuring human flourishing. The social theory implicit in the concept of the common good has significant implications for health care of the elderly and situates the theological consideration of justice that follows within a social matrix. A richly textured theological understanding of justice looks not only to the way it contributes to the common good but emphasises a particular bias that enables individuals or groups to move from the margins to the mainstream of social life. This particular dimension of justice as preferential option for the poor has direct implications for this thesis as it analyses the question of just health care for elderly Australians.

8.1 THE HUMAN PERSON

8.1.1. The Notion

From the historical viewpoint the term *person* has been used in different ways. In the bible a person is one who is capable of knowledge and love and of functioning as a responsible moral agent. This understanding is theocentric; human dignity flows from the person's relationship with God. "The biblical concept of *person* is not only relational but also dynamic. The person is both an essential structure and an ongoing task."[1] Philosophically the notion of person as "an individual substance of a rational nature" structured Christian thought in the West for many centuries.[2] The hallmarks of this approach are individuality and rationality. A human person in this perspective is, therefore, any individual member of the human race who shares in the nature which characterises our species *homo sapiens*.[3]

The modern concept of *person,* however, is anthropocentric.[4] The human is understood as the independent, autonomous subject whose independence must be safeguarded from the incursions of society. This modern concept of the person had its origins in western Europe in the breakdown of medieval unity, a breakdown that ushered in the individualism that has remained a trademark of the modern world. The rationalism of the Enlightenment placed the autonomous subject at the centre of a world that had been stripped of mystery and in which God was, at best, a somewhat benign if distant observer of the human scene. Since John Locke philosophers have "so defined what it is to be a person that persons are a subclass of human beings: they are those human beings who possess presently exercisable psychological abilities, and more particularly the abilities to understand, choose and communicate."[5]

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1 J. C. Dwyer, "Person, Dignity of" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn.: The Liturgical Press, 1994), 725

2 "naturae rationabilis individua substantia" This definition of Boethius was designed originally to establish a case in the controversies surrounding the nature of Christ. Cf. A. V. Campbell, "Persons and Personality" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 470

3 L. Gormally, "Definitions of Personhood. Implications for the Care of PVS Patients", *Catholic Medical Quarterly* 44 (1993): 7

4 Campbell observes, correctly I believe, that the terms *person* and *personality* attempt "to describe that which must inevitably elude precise definition - the particularity and open-endedness of individual human existence." Campbell, "Persons and Personality" in *A New Dictionary of Christian Ethics*, 472

5 Gormally, "Definitions...," *Catholic Medical Quarterly*, 7. This issue of personhood underpins much recent legal and bioethical discussion regarding persistently vegetative state (PVS)

The bible views the human person as a creature of God, as an animated body. As noted earlier our bodiliness is the basis of our relationship with one another. In other words human existence as bodily enables human coexistence. But such individual and corporate existence is fraught with as many risks as opportunities. Human existence is at once responsible, sinful, and hope-filled. The focus of human hope is the resurrection of the body. The ground of that hope is the preaching, ministry, and saving death and resurrection of Jesus Christ whom Christians accept in faith and to whom they manifest their fidelity in love. To live according to this dynamic of faith, hope, and love is to enter a new life, to become a "new creature in Christ". This new life and new creaturehood is, as always, shared with others, in accordance with our social nature. The immediate context of the sharing is the community of the faithful, which is the Church.[6]

Until modern times, there was little or no significant development in a theology of human existence beyond that already expressed in the bible. Early Christian writers, especially Irenaeus, spoke of the human person as the *image of God*, and of human history as the *history of salvation* - a process in which all things are being *recapitulated* in Christ.[7] This notion was borrowed from Paul's letters and considerably expanded.[8]

The medieval period viewed human existence *objectively*, that is as an unchanging form of created life essentially unaffected by the process and vicissitudes of history. This static view meshed with the wider philosophical and political frameworks of the period. Elements in medieval theology anticipated, to some extent, the modern turn toward the subjective as can be found in theological discussions of conscience and its role in the moral life.[9]

As a result of scientific and philosophical developments and under the influence of post-Enlightenment philosophical concerns, contemporary theology has concentrated

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patients, (e.g. Bland case in the House of Lords) and the use of anencephalic infants as tissue and organ donors.

6 R. P. McBrien, *Catholicism*, completely revised and updated edition, (North Blackburn, Vic.: Collins Dove, 1994), 166-167

7 Cf. Kelly, *Early Christian Doctrines*, 170-174

8 "when He became incarnate, and was made man, He commenced afresh [*in seipso recapitulavit*] the long line of human beings, and furnished us, in a brief, comprehensive manner, with salvation; so that what we had lost in Adam - namely, to be according to the image and likeness of God - that we might recover in Christ Jesus." Irenaeus, "Against Heresies", in *The Ante-Nicene Fathers*, edited by A. Roberts and J. Donaldson, Vol. 1, III. 18.1, (Grand Rapids, Mich.: Wm. B. Eerdmans, 1979), 446

9 Cf. T.C. Potts, *Conscience in Medieval Philosophy*, (Cambridge: Cambridge University Press, 1980)

on (1) the consciousness of the human person, (2) the person's freedom and responsibility, not only to co-create himself or herself but to co-create the world and its history under God, and (3) the radical equality of men and women in the human community. The Second Vatican Council's insistence on the importance of conscience, freedom, and the innate desire for a higher life reflects this modern shift to the subject. The Council's emphasis on the social, historical and worldly dimensions of human existence underscores the human person's responsibility for others, for the world and its history and ultimately for the coming of the final reign of God. The Council affirmed the fundamental equality of men and women thus providing the foundation stone for a formal, de facto recognition of that equality in both society and the Church.[10]

8.1.2 The Human Person in Contemporary Systematic Theology

Theology of the human person (or theological anthropology), has been a dynamic and evolving area of reflection in Catholic theology from 1965. For the purposes of this thesis three strands are particularly relevant: (1) the understanding of the human person that has developed in Catholic social justice doctrine, (2) perspectives enriched by renewed interest in the theology of the Trinity and (3) a reappraisal of Creation theology as a result of current ecological concerns. These developments are noteworthy since they underpin the theological personalism of contemporary Roman Catholic moral theory. All three areas of reflection in systematic theology point to the interconnecting influences occurring as a result of the Church taking seriously its commitment to reading the "signs of the times" and sharing in the "joy and hope, the grief and anguish of the men of our time".[11] In its struggle to come to grips with social, economic and political issues the Church's social doctrine has given an increasingly important place to the dignity of the human person. A renewed biblical personalism has enhanced an understanding of the Trinity as *mutuality-of-persons-in-communion*. This has complemented a growing awareness that the human person relates in an interdependent way with all created things. It is to these three strands of reflection that this study now turns.

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[10] *Gaudium et spes*, nn.12-22 in Flannery, *Vatican Council II*, 913-924 offers a survey of the anthropology now envisaged by the Church. The person is envisaged as *image of God* and as *social* (nn.23-32 in Flannery, *Vatican Council II*, 924-932). Cf. J. Moller, A. Sand and K. Rahner, "Person. II. Man" in *Sacramentum Mundi. An Encyclopedia of Theology*, edited by K. Rahner, Vol. 4, (London: Burns & Oates, 1969), 415

[11] *Gaudium et spes*, n.1 in Flannery, *Vatican Council II*, 903

8.1.2.1 The Human Person in Catholic Social Justice Teaching

Teaching on human rights in the Catholic Church developed only after more than a century and a half of resistance to rights movements in western Europe and the U.S.A. Although a late starter in this arena, Catholic social thought has developed rapidly since the time of Pope Leo XIII (1878-1903).[12] With his encyclical *Rerum novarum* (1891) the pope examined the living conditions of the poor and workers in industrialised countries. After detailing a number of important principles that should guide people as they confronted the problems of the time Leo articulated the rights and duties applicable to workers, employers, the wealthy, public authorities and the law. The encyclical viewed society and its institutions in static and even patriarchal terms.[13] The just wage was a prime concern in the papal letter since it was judged to be a necessary condition for ensuring the human dignity of workers who were experiencing harsh working conditions and low pay in the industrial cities of western Europe.[14]

Pius XI in his 1931 encyclical *Quadragesimo anno*, commemorating the fortieth anniversary of *Rerum novarum*, wrote at a time when the depression was shaking the economic and social fabric of the modern world. In criticising the abuses of both capitalism and communism the pope attempted to update Catholic social teaching to reflect the changed social conditions. He broadened the Church's concern for poor workers to encompass the structures which oppressed them. In this he broke with the static framework of his predecessor. Pius was concerned not only with the conditions of workers but with the whole socio-economic ordering of nations. He introduced into official Church teaching the term *social* justice and focused on the basic causes of injustice by undertaking what is now called a *structural analysis* of society.[15] The personal dignity of workers could be ensured, Pius argued, if society adopted vocational structures that would remove class divisions in society.[16] This suggestion

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[12] For a detailed study of the social justice teaching of the Church since 1891 see D. Dorr, *Option for the Poor. A Hundred Years of Vatican Social Teaching*, revised edition, (Blackburn, Vic.: Collins Dove, 1992); cf. McBrien, *Catholicism*, rev.ed., 1001-1007; C. E. Curran, "The Changing Anthropological Bases of Catholic Social Ethics" in *Moral Theology: A Continuing Journey*, (Notre Dame, Ind.: University of Notre Dame Press, 1982), 173-208.; C. E. Curran, "Official Roman Catholic Social Teaching" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 429-33

[13] The organic view of society underpinning Leo's thinking is continuous with the view of Aquinas, was influenced by nineteenth century European reaction to the French Revolution and by domestic concerns about the Papal States and Italian nationalism.

[14] For brief summaries of each of the social encyclicals see P. J. Henriot, E. P. DeBerri and M. J. Schultheis, *Catholic Social Teaching. Our Best Kept Secret*, (Melbourne: Dove Communications, 1987)

[15] Dorr, *Option for the Poor*, 76

[16] Dorr, *Option for the Poor*, 80-81

resonates with the image of the medieval guilds where artisans and skilled workers enjoyed equal status in such associations.[17] In his 1944 Christmas address Pius XII furthered papal teaching on social issues by arguing that the power to participate in the political process, and thus the capacity to shape one's own future, was essential for preserving and developing human dignity.[18]

Pope John XXIII published the encyclical *Mater et magistra* (1961) in response to the great imbalances between the rich and poor in the world. This letter is significant in that it internationalised Catholic social teaching by considering the plight of non-industrialised nations. The pope was intensely aware that the complexity of the modern world causes a loss of power in individuals who are, as a consequence, unable to shape their lives. This powerlessness assaults the dignity of the human person. In his 1962 letter *Pacem in terris* Pope John argued that peace in the world needs to be based on an order "founded on truth, built according to justice, vivified and integrated by charity, and put into practice in freedom." At a time when the world was intensely aware of the threat of nuclear war the pope addressed "all people of good will", endorsing a philosophy of rights and urging a greater level of human community among the peoples of the world.

Vatican Council II in its document on the Church in the modern world, *Gaudium et spes*, explicitly adopted an historically conscious outlook. Human institutions and human persons are not static but develop and change in history. The Council also adopted an explicitly theological point of view in identifying the human person and the dignity that is due to each human being. The challenge for human beings is to live as finite beings called to absolute transcendence. The Council no longer viewed the human person and human dignity in negative and individualistic terms but rather in terms of the right to share in the decisions that structure political, social and economic life. This marked a new focus in Catholic teaching. High priority is now to be given to an *option for the poor* when *Gaudium et spes* proclaimed that:

> God destined the earth and all it contains for all men and all peoples . . . Therefore every man has the right to possess a sufficient amount of the earth's goods for himself and his family.[19]

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17 It has been suggested that the corporative state being introduced into Italy by Mussolini at that time influenced Pius's approach. However, at the theoretical level, it was Pius's use of the *principle of subsidiarity* that provided the rationale for vocational groupings in society.

18 J. C. Dwyer, "Person, Dignity of" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn.: The Liturgical Press, 1994), 726

19 *Gaudium et spes*,n.69 in Flannery, *Vatican Council II*, 975

This concern for the poor of the world reveals a moral obligation in which people are "bound to come to the aid of the poor and to do so not merely out of their superfluous goods."[20]

Pope Paul VI advanced Catholic social justice thinking in his encyclical letter *Populorum progressio* (1967) when he addressed the challenges of human development. He proposed the notion of *integral* development where human dignity is to be protected by promoting the development of the whole human being, by realising the human potential for knowledge, responsibility and freedom in every area of life. These are not merely instrumental in attaining human dignity but become an integral part of the process. On the eightieth anniversary of *Rerum novarum* Paul VI addressed the wide variety of new problems resulting from rapidly increasing urbanisation around the world. His Apostolic Letter, *Octogesima adveniens* (1971) continued the more theological approach to social issues initiated by Vatican II "by suggesting that Christian faith, in virtue of its conviction that absolute value and truth had taken historical form in Jesus, was in a unique position to reconcile the claims of the absolute and the relative, of historicity and transcendence, in the quest for practical means of promoting human dignity."[21]

Three further documents complete this brief survey of an evolving Catholic social teaching. In the document, *Justitia in mundo*, of the Roman Synod of 1971 the bishops taught that the right to development and participation, at both personal and communal levels, is the foundation of all other rights. Marginalisation is the greatest threat to human dignity today. This denies human beings the power to shape their own destiny in the political, social, and economic realms of life. In *Laborem exercens* (1981) John Paul II affirmed the dignity of human work and placed work at the centre of social analysis.The human person is the *subject* of work. For this reason work must always be a form of self-realisation. It is through work we become more fully human. In *Sollicitudo rei socialis* (1988) the pope continued to emphasise the centrality of the human person in the Church's social justice teaching by focusing on the solidarity that obligates people to work for the common good. He also referred to the obstacles hindering true human development as the *structures of sin*. In doing this the pope called all to a conversion that expresses itself in *solidarity* and that takes seriously the *option for the poor*.

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20 *Gaudium et spes*,n.69 in Flannery, *Vatican Council II*, 975. This interdependence of all persons leads to the virtue of solidarity as we will see it developed later by John Paul II in *Sollicitudo rei socialis*. Cf. Dorr, *Option for the Poor*, 160

21 Dwyer, "Person...," in *The New Dictionary of Catholic Social Thought*, 727

This brief sketch of a hundred year development in Catholic social justice teaching indicates an evolving understanding by the official Church of the human person. This process was to a great extent provoked by forces external to the Church, by the lives and living conditions of people, initially in western Europe and since the 1960s in the world at large. Three aspects of this developing notion of what it means to be a person in the modern world have relevance to the direction of this thesis. First, the dignity of the human person is inextricably linked to the human context or environment in which the individual lives. Chapter 1 has illustrated this factor already in reference to the aged in Australia. Second, the human person is the norm for assessing all human living and activity. John Paul II's analysis of human work suggests that human labour is integral to a fully human life. This has significance for the elderly who, upon retirement, are frequently judged to be non-productive and recipients of welfare and health care. Third, an understanding of the human person as interdependent entails a notion of responsibility for others, a preference for the poor. No group is excluded from this responsibility. It applies equally to the elderly and the poor and should influence what may be expected of them and how they should contribute to the common good.

8.1.2.2 The Person and Trinitarian Theology

The Christian understanding of God cannot be expressed fully, let alone explained, apart from the doctrine of the Trinity and the person and work of Jesus Christ.[22] Catholic theology in the pre-Vatican II period separated the so called *economic* Trinity from what is called *immanent* Trinity. For many centuries the latter was emphasised in theology and catechesis as an almost arcane description of the inner life of God, as if it was of concern only God and not ourselves. What Christ asked us to believe about the trinitarian life was all that mattered. More recently, however, theology came to certain conclusions about the inner reality of God based on the experience of God within human history. In other words theologians began to wonder theologically and doctrinally whether there is more to God than traditional monotheism suggests. Knowledge of God as triune developed through reflection on

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22 Two currents of analysis dominate current theology: (1) a christological approach which sees Christ as restoring the imbalance in humanity created by sin. Cf. J. Macquarrie, *Jesus Christ in Modern Thought*, (London: SCM Press, 1990), 293-335; E. A. Johnson, *Consider Jesus. Waves of Renewal in Christology*, (New York: Crossroad, 1990). (2) The trinitarian emphasis views Christ as restoring us to right relationship to the Trinity and to others. I focus on this latter strand of reflection which emphasises the aspects of mutuality and communion. The orthodox theologian John Zizioulas has been especially influential on Catholic scholars writing on this aspect of the trinity. Cf. J. D. Zizioulas, *Being as Communion. Studies in Personhood and the Church*, (Crestwood, N.Y.: St. Vladimir's Seminary Press, 1993). For a general survey of contemporary trinitarian theology see M. A. Fatula, *The Triune God of Christian Faith*, (Collegeville, Minn.: The Liturgical Press, 1990)

the way the triune God has dealt with us in history. The God whom we experience as triune in history (the *economic* Trinity) must also be Triune in essence (the *immanent* Trinity). The biblical and theological renewal surrounding the Second Vatican Council enabled theologians to understand the Trinity not as a speculative doctrine but as the "way we express our most fundamental relationships with the God of our salvation as well as God's relationships with us."[23]

The Christian doctrine of the Trinity is an elaborate spelling-out of the most basic Christian proclamation that God is love-for-us, pure self-gift.[24] The classic doctrine of the Trinity is an attempt to understand the freedom of that self-gift. In traditional Christian imagery, the Father gives himself totally to the Son, the Son gives himself totally to the Father, and the Spirit, proceeding from both, is the bond of that pure self-giving love.[25] At the heart of the doctrine, and the deepest claim that Christians make about being in all its facets, is that *to be* and *to love* are synonymous. The doctrine developed because Christians found it a most suitable description of their experience of shared life. Basic to that experience is that we know ourselves as social, communal in the very structure of our being, in other words as essentially political. Thus the doctrine makes a political statement. It maintains that not only is human existence social but that the ground of all being is relationship.[26]

The call to communal responsibility, rather than being a peripheral aspect of human existence, is located at the very core of life. Christians express this community-centred core through their faith in the Trinity. In addition, the Trinity must be understood as radical and holy mystery, as beyond human power to ever fully understand even in heaven. Appreciating God as inexpressible mystery influences in important ways how we look at issues like just health care. If God is radical mystery then humans never fully understand life and its future, they never fully comprehend where they are going nor do they know what wonderful things God might have in store for them not only in heaven but also here on earth. In other words, God's mysteriousness makes them a restless people who are never quite satisfied with things the way they are. We are a people always looking for new options, a people hoping new hopes and dreaming new dreams.[27]

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23 McBrien, *Catholicism*, revised ed., 323

24 Cf. 1 Jn.4:8, 16

25 For a recent effort in rethinking our understanding of the Trinity see T. G. Weinandy, *The Father's Spirit of Sonship. Reconceiving the Trinity*, (Edinburgh: T & T Clark, 1995)

26 Simons, *Competing Gospels*, 71; cf. M. J. Himes and K. R. Himes, *Fullness of Faith. The Public Significance of Theology*, (New York: Paulist Press, 1993), 55-61

27 Keane, *Health Care Reform*, 106

In contemporary theology the immanent Trinity is thought of in terms of mutual relationships while the economic Trinity is portrayed as dynamic and ecstatic self-communication. These two ways of looking at the triune God function in a complementary fashion permitting different dimensions of the relationship to be hightlighted. There can be, however, a tension between emphasis on mutuality, equality and the divine *perichoresis* on the one hand, and a focus on trinitarian dynamism, relationships of origin, distinction of Persons and dynamic relationship with creation on the other.[28] Denis Edwards, the Australian theologian, notes that:

> Authentic trinitarian doctrine is a constant reminder that mutuality and distinction are not to be seen as opposites, but as always requiring each other. Genuine mutuality of relationships will always involve dynamic distinctions. Both are essential for trinitarian theology . . . [I]t is important to keep in mind two complementary trinitarian principles: the principle of mutual relationships on the one hand, and the principle of distinction, dynamism and process on the other.[29]

A public theology grounded in the Trinity provides the deepest foundation possible within the Christian tradition for a radical challenge and alternative to the individualistic bias of current secular understandings of the person as rational economic agent, as well as of society as an aggregate of individuals.[30]

Placing the doctrine of the Trinity in conversation in the public realm argues for two changes in the way the relationship between individuals and communities should be understood. First, since being and self-giving love are identical in trinitarian theology, individual existence may be understood as originating in and arising from a relational context. The Trinity is portrayed in terms of *persons-in-mutual-relationship*, where both individuality and mutual community coexist in mutual interdependence.[31] What follows from this is that individual existence is never the precondition for community. Rather, community is understood as the indispensible context out of which individual identity emerges. For God is essentially community, relationship, Trinity, self-giving love. Where Aristotle observed that the human person is intrinsically political, Christianity teaches that God is intrinsically relational and, by implication, political. Since God's relational-political existence is the ground of all being, it follows that humanity, existing in God's image, is radically and fundamentally relational-political. The *image of God* language is often invoked as a

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[28] *Perichoresis* or *circumincession* refers to the reciprocal presence, or indwelling, of the three divine Persons in one another in the Trinity.

[29] D. Edwards, *Jesus the Wisdom of God. An Ecological Theology*, (Homebush, N.S.W.: St. Pauls, 1995), 112

[30] Simons, *Competing Gospels*, 71-72

[31] Edwards, *Jesus the Wisdom of God*, 136-137

theological basis for claiming that the human being, like God, is capable of self-gift. A trinitarian and communitarian understanding of God provides a perspective where the individual and the community give life to one another. Indeed, the broader and deeper the network of relationships, the more truly human the community and the individual. The most fundamental human activity in this scheme of things is found in the exercise of self-giving love. This provides an opportunity to enter into relationship and to participate in the life of the human community.

A trinitarian understanding of personhood as relatedness-to-others in a politically inclusive community assists theologians to articulate a number of identifying traits of personhood.[32] The first is that persons are *interpersonal* and *intersubjective*. An isolated person is a contradiction in terms, just as an isolated God or a God incapable of relationship is irreconcilable with the revelation of God in Jesus Christ. The doctrine of the Trinity is indispensable for preserving the relational character of God, the relational nature of human existence and the interdependent quality of the entire universe.[33]

A second identifying trait of personhood from a trinitarian perspective is that persons are *unique* and *unrepeatable*. No two relational histories are identical and no two sets of relationships constitutive of personal identity could ever be the same. Furthermore, unique personhood emerges in interdependence and also requires a balance of self-love and self-gift. Each new relationship or cluster of relationships brings about a new and evolving reality. In addition, unique personhood constituted by interdependence is the bridge between ourselves and everything and everyone else, past, present and future. The inclusiveness of the person invites us to overcome a fear of diversity and loss of personal identity. Furthermore, the basic good of a person's life is of its very nature something which has an impact on the life of all creation. The life of each individual person is part of and relative to the whole. Thus, the final good of all human beings implies the mutual interrelationship of persons in community.[34]

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[32] C. M. LaCugna, *God for Us. The Trinity and Christian Life*, (San Francisco: Harper, 1991), 288-292

[33] Simons, *Competing Gospels*, 72-73. Augustine defended the Latin use of *persona* of the Trinity. He insisted that a person does not exist "as directed to self" but "as directed to others" (*De trinitate*, 7,6,11). Aquinas, consistent with his position that terms predicated of God and creatures are done so properly of God and only by extension to creatures, taught that *person* applies preeminently to God. (S.T. I, 13,2). This is because in God relation is not something added to God's existence, but is already an expression of how God exists (S.T. I, 29,4). (*ibid.*, 73)

[34] Simons, *Competing Gospels*, 36-37

Trinitarian theology, with its priority on persons-in-relationship, contradicts contemporary preoccupations with the *economic person*. Clear differences between these two world-views are played out in the practical sphere. For the elderly two aspects are important. The personal identity and status of the aged are assured when they live as persons-in-relationship. A communal environment enabling the give-and-take of mutual relations is vital for a fully human existence. This presumes a two-way empowering: by the aged of those who are younger, by the sick and frail elderly of those who care for them. This is possible when the equality of persons in the relationship is acknowledged.

8.1.2.3 The Human Person in Creation Theology

Living as persons in communion, in right relationship, is the meaning of *salvation* and the ideal of Christian faith. The German theologian Walter Kasper has described the doctrine of the Trinity as the "grammar" and "summation" of creation and salvation.[35] "*Creation* and *salvation* are categories which attempt to describe what it means to find one's origin in God's self-giving love and to be sustained by that same love, precisely as they are gifted dimensions of humanity's historical existence."[36] In contrast to the individualistic self-interest which motivates the rational economic agent, a trinitarian view of the human person and human salvation provides a decisively more respectful alternative for affirming the importance of community welfare for individual well-being.

Reflection on historical existence has moved theological analysis beyond an anthropocentric view of salvation to a broader ecological and cosmic framework. God's new creation implies a transformation of all creatures. Integral human liberation needs to be seen in this context. Such a theology of salvation must situate human liberation, including individual, ecological, interpersonal, political and religious dimensions of liberation, within the context of the redemption of all creation.[37] In schematic form, such a theology of salvation involves two dimensions. First there is God's transformation of the whole universe. Salvation in Christ embraces every element of the created universe. Second, there is God's self-offering in saving grace to human beings and his invitation to them to participate, in a human way, in the divine work of ongoing creation and redemption. God's liberating grace,

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35 W. Kasper, *The God of Jesus Christ*, (New York: Crossroad, 1984), 311

36 Simons, *Competing Gospels*, 74

37 Cf. Rom 8:21; Col.1:20

and our call to participation, involve all the dimensions of human existence. Salvation then becomes a concept that embraces the whole of creation."[38]

The doctrine of creation in Christian theology has a double impact. First, it affirms the priority of social relationships and community for the development of persons. This aspect has already been considered in reference to the Trinity. Second, creation doctrine heightens our sense of relatedness to, and community with humans and all in nature.[39]

This double dimension may be observed in contemporary readings of the creation stories. Gen.1:1-2:4a and Gen. 2:4b-25 both depict the human capacity for relationship as that which makes humanity "like God". Gen.1 has been the basis of a long theological tradition emphasising human *dominion* and *stewardship* over the natural world. In this human persons *image* God. Gen.1:27 states "and so God created the human being in God's image; male and female did he create them." The point in the narrative is not that God is male or female, but that God is relational. The only God that the Hebrew tradition knew was the God in continuing and developing relationship with all of creation. To be the image of this God, the human being must be relational.[40]

Gen.2:4b-25 tells the story of Adam naming the animals of creation in the context of the human hunger for companionship. Not only is companionship the explicit ground for the creation of the two sexes, it is also the reason for the creation of the "various wild beasts and birds of the air".[41] The natural world is not intended merely for subjugation by human beings, but for companionship. The challenge made when an appeal is made to the doctrine of Creation is to broaden our understanding of the human person so as to include nonhuman creation as companion to humanity. The Catholic tradition offers two important symbols for reappropriating the biblical theme of companionship in creation: poverty and sacramentality.[42]

All creatures are united in the depths of their being by the fact of being creatures. The source and foundation of one's being is not in oneself since there is no intrinsic reason for one's being at all. This *poverty* unites all creatures. In this fundamental poverty there is equality of intrinsic value. The Christian doctrine of the Incarnation

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[38] Edwards, *Jesus the Wisdom of God*, 149-150

[39] Simons, *Competing Gospels*, 74; cf. Himes and Himes, *Fullness of Faith*, 105-120

[40] Simons, *Competing Gospels*, 75

[41] Gen. 2:19

[42] Simons, *Competing Gospels*, 76

affirms humanity's role as one of extraordinary dignity. That dignity, however, involves the recognition of the inherent value of all creation. The point of linkage is to be found in the sphere of bodiliness. As noted earlier in this thesis creatures are always interconnected in the sphere of bodiliness. Through our bodies we reach out into a sphere which does not belong to ourselves alone. Bodily existence involves us with a world of other creatures. There is no inwardness in us that is not touched by what comes from without. At the very centre of our beings we always have something to do with other human creatures as, for example, with the food we eat, the air we breathe, the flowers we smell, the wind which brings rain. And we necessarily have something to do with Jesus, whose death two thousand years ago took place in a bodily sphere which is still ours today. We live in a common sphere that makes all communication between creatures possible, a space which is in one sense our common body.[43]

Contemporary scientific explanations about the beginnings of the universe and all forms of life reinforce a conviction that humans have a communal heritage with all other creatures. This common story of the universe suggests that the human person is profoundly and intrinsically interconnected with every other creature as a child of the earth and a child of the universe. The human person has the particular dignity and responsibility which come from being one in whom the universe has come to self-awareness.[44]

The themes of creation and poverty intersect in the Catholic vision of *sacramentality*. The identifying trait of a sacrament is the capacity to reveal the self-giving love of God by being what it is. A sacrament gives bodily expression to the self-giving love of God that undergirds both it and all of creation. Every creature, human and nonhuman, animate and inanimate, can be a sacrament. A sacrament has been referred to as a reality imbued with the hidden presence of God. A sacramental perspective is one that *sees* the divine in the human, the infinite in the finite, the spiritual in the material, the transcendent in the immanent, the eternal in the historical. In this perspective all reality is sacred.[45]

This much more richly textured understanding of creation contributes greatly to an understanding of the human person as the *image of God*. The latter is a theological

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[43] Karl Rahner has suggested that our eternal destiny may have something to do with our acceptance of this transformed bodily sphere, in which we always necessarily are. Cf. Edwards, *Jesus the Wisdom of God*, 138-139

[44] Edwards, *Jesus the Wisdom of God*, 143

[45] McBrien, *Catholicism*, revised ed., 9-10; cf. Himes and Himes, *Fullness of Faith*, 113

statement before it is an anthropological one. It gives priority to saying something about the relation between God and us which has implications for what it means to be human.The biblical truth about the human person is that being the image of God is irreversible. As an anthropological statement *image of God* says that we all share the common human condition as creatures with a common end, namely God. It also says that human dignity does not depend ultimately on human achievements but on divine love.[46]

Aspects of this reflection on the human person in creation theology have particular significance for this study on just health care for aged Australians. The first is located in the fundamental role of bodiliness in human existence. As creatures every human in the experience of his or her bodiliness is companion in a fundamental way to all else in creation. This is discussed elsewhere in terms of interdependence and solidarity. What makes this a significant notion for health care of the aged is the respect and attention that should be given to the bodiliness and aging bodies of the elderly. The variety of limits that manifest themselves in the senescent body of an aging person must not blind carers of the elderly to the fact that the very bodiliness of the elderly provides the privileged medium for mutual contact. It is a reminder to both the aging person and those who care for them of both the reality of human limitation (our shared poverty) and human mystery (our sacramentality). This insight has radical implications for the way others should deal physically with the elderly person present to them in a uniquely bodily way. Even when recipients of care given by others the aging bodies of the elderly and their experience of being bodily instruct those who care.

8.1.3 The Human Person in Contemporary Moral Theory

The shift in world-views that has occurred in Catholic theology during the last half-century has already been considered in Chapter 6 in terms of the transition from a *classicist* model to an *historically conscious* model of doing theology. [47] Both the classicist and historicist mindsets follow a predominantly rationalistic approach that has dominated our Western intellectual tradition since the time of the medieval scholastics. Throughout its long history, however, Christianity has depended on

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[46] Gula, *Reason Informed by Faith*, 64-65; cf. G., V. Lobo, *Guide to Christian Living*, 79-81

[47] The Canadian Jesuit philosopher Bernard Lonergan has been a significant influence in English speaking theological circles by offering both insight and rationale into this shift in method. B. J. F. Lonergan, "The Transition from a Classicist World-View to Historical Mindedness" in *A Second Collection. Papers by Bernard J.F. Lonergan S.J.*, edited by W. F. J. Ryan and B. J. Tyrell, (London: Darton, Longman & Todd, 1974), 5-6

powerful images and symbols to give intellectual expression to its self-consciousness.[48] Symbols, like signs, point to another reality but, unlike signs, they also participate in the reality to which they point. A symbol makes present that to which it points. It is, in other words, sacramental.

Revelation as symbolic disclosure has received wide attention among twentieth century Christian theologians. A parallel has been drawn between the properties of symbolic communication and those of revelation. First, symbolic consciousness gives not only speculative but also participatory knowledge, luring us to situate ourselves within the universe of meaning and value which it opens up to us. Second, it involves the knower as person and has a transforming effect. Third, it has a powerful influence on commitments and behaviour, and finally it introduces us into realms of awareness not normally accessible to discursive thought.[49] Symbolic consciousness does not desert the concrete or the historical but rather sees it as revelatory of deeper meaning. It gives emphasis to mystery and, of its very nature, symbolic consciousness is relational:

> Because it always points beyond itself to its 'other half' and because it finds its first expression in stories and myths, which are always the properties of communities, the symbolic overcomes the individualistic and objectivistic tendencies of the rational approaches. The symbolic is primordial. It is common to all peoples and to individual persons in their earliest stages. Only at a certain point in development does it open up to abstract reasoning, which must always remain connected to its roots in the symbolic and not strive to replace it.[50]

Attention to the symbolic is essential for a more comprehensive notion of the human person. Because of this the reductionist approach of much Roman Catholic moral theology in the past is being overcome. The human person was often viewed, particularly in the manuals of moral theology, as the sole *locus* of physical and moral activity. In light of this fact it is possible to appreciate the evolving personalist dimension of recent Catholic moral thinking. The seeds of this transformation were sown when the Second Vatican Council asserted that the "moral aspect of any procedure . . . must be determined by objective standards which are based on the

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[48] *Symbol* (Greek *symballein*) literally means to fall together, to throw together. It refers to the two corresponding halves of a ring or tablet that were used as tokens of identity for guests, messengers or partners of a treaty. A *symbol* is something that points to its complementary other half creating mutual recognition and unity. D. Bohr, *Catholic Moral Tradition: In Christ, A New Creation*, (Huntington, Indiana: Our Sunday Visitor, 1990), 70

[49] A. Dulles, *Models of Revelation*, (Garden City, N.Y.: Doubleday, 1983), 136-137

[50] Bohr, *Catholic Moral Tradition*, 72

nature of the person and the person's acts."[51] The official commentary on this wording notes two points: (1) the Council's text formulates a general principle that applies to all human actions, and (2) the choice of this expression intends that "human activity must be judged insofar as it refers to the human person integrally and adequately considered."[52]

Louis Janssens' study of this expression has contributed signficantly to the development of a moral personalism in contemporary moral theology.[53] He has understood the phrase as referring to the fundamental and constant aspects or dimensions of the human person. Eight dimensions have been proposed.[54] The human person is (1) a subject, (2) an embodied subject, (3) part of the material world, (4) interrelational with other persons, (5) an interdependent social being, (6) historical, (7) equal but unique, (8) called to know and worship God. When the person is "integrally and adequately considered" all of these essential elements must be taken into account. Actions that promote the person adequately considered in this way are morally right. Those that attack or undermine the person are morally wrong. The Council thus placed the *whole* person at the centre of all moral evaluation. Note has already been made of the way Pope John Paul II has elaborated this understanding in his analysis of the role of work in human life.

A person-centred moral methodology has far reaching implications for health and healing in the Catholic tradition. Jesus' exercise of power, as noted already, is presented in the gospels as healing, liberation and restoration to wholeness.[55] These three dimensions of health care unambiguously indicate a morality where human

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[51] "Moralis igitur indoles rationis agendi,...sed obiectivis criteriis, ex personae eiusdemque actuum natura desumptis, determinari debet,... *Gaudium et spes*, n.51 in *Enchiridion Vaticanum. Documenti il Concilio Vaticano II*, 9th. ed., (Bologna: Edizioni Dehoniane, 1971), 872

[52] "Elementa ex utraque hac propositioni retinendo, proponitur ut loco '*in eadem personae dignitate fundatis*', dicatur: '*ex personae eiusdemque actuum natura desumptis*'; quibus verbis asseritur etiam actus diiudicandos esse non secundum aspectum merum biologicum, sed quatenus illi ad personam humanam integre et adequate considerandam pertinent." *Acta Synodalia Sacrosancti Concilii Oecumenici Vaticani II*, Vol.4, part 7, (Vatican City: Typis Polyglottis Vaticanis, 1978), 502, n.37

[53] Louis Janssens is emeritus professor of moral theology at the Catholic University of Leuven in Belgium. Cf. L. Janssens, "Artificial Insemination: Ethical Considerations", *Louvain Studies* 8 (1980): 3-29 which builds on earlier studies: L. Janssens, "Personalist morals", *Louvain Studies* 3 (1970): 5-16; L. Janssens, "Norms and priorities in a love ethics", *Louvain Studies* 6 (1977): 207-38.

[54] Each of these elements of a moral anthropology has been discussed already in Chapters 6 and 7. Cf. Kelly, *New Directions in Moral Theology*, 31-60 for an excellent study of each of the eight dimensions.

[55] Cf. T. E. Clarke, "Touching in Power: Our Health System" in *Above Every Name. The Lordship of Christ and Social Systems*, edited by T. E. Clarke, (Ramsey, N.J.: Paulist Press, 1980), 259

activity is judged "insofar as it refers to the human person integrally and adequately considered". Where health care of the elderly is concerned attention must be paid to all that goes to make the aged person unique - the story of their journey to old age, their family, their completed and yet unfinished life projects, their physical, psychological and spiritual needs and expectations. Against this comprehensive understanding of the human person must be placed the role and good of the human community. This dimension has traditionally been considered in Roman Catholic theology under the rubric of the *common good.* It is to this that we now turn.

8.2 THE COMMON GOOD

8.2.1 The Notion

The term *common good* was little used in Roman Catholic literature from the end of the Second Vatican Council until the late 1980s.[56] Just prior to the Council Pope John XXIII had defined the common good as "the sum total of those conditions of social living whereby people are enabled more fully and more readily to achieve their own perfection.[57] The definition assumes a social view of the human person, that individual human beings are the foundation, the cause and the end of every social institution and that the perfection of the individual and society consists in the right ordering of man's conscience with God.[58] These three notions map the principal elements of common good thinking as it has developed historically and as it is being re-evaluated in contemporary Catholic theology.

Common good doctrine asserts that there exists a good for society as a whole which respects, but is ultimately more important than, the good of any individual.[59] It also argues that everyone ought to share in the benefits and burdens of living in a society and that the common good requires that others live on a par with ourselves.[60]

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[56] Williams notes that only one entry for the term can be found in the *Catholic Periodical and Literature Index* in the twenty years prior to 1986. O. F. Williams, "To Enhance the Common Good: An Introduction" in *The Common Good and U.S. Capitalism*, edited by O. F. Williams and J. W. Houck, (Lanham, Md.: University Press of America, 1987), 1

[57] *Mater et magistra*, n.65 in *The Gospel of Peace and Justice. Catholic Social Teaching since Pope John*, edited by J. Gremillion, (Maryknoll, N.Y.: Orbis, 1976), 157; cf. A. Nemetz, "Common Good" in *New Catholic Encyclopedia*, Vol. 4, (New York: McGraw-Hill, 1967), 15

[58] *Mater et magistra*, nn.219, 215 in *The Gospel of Peace and Justice*, 190, 189

[59] Keane, *Health Care Reform*, 130

[60] D. Christiansen, "The Great Divide: Catholic Social Teaching and American Health Care", *The Linacre Quarterly* 58 (1991): 45

Common good is a descriptive term that carries normative clout.[61] It is not something given, something already out there like a piece of property:

> Reference to the common good is reference to what ought to be done to move us toward what we might be. A synonym for the common good would be flourishing sociality. That sociality which is of our nature implies that we will not reach fruition in solitude. Individual good is realized within the common good.[62]

It is impossible to define the *common good* in a final way irrespective of changing social conditions.[63] While this teleological term is widely used to point to shared or public values and interests it is given particular prominence in the social teaching of Roman Catholicism. There it expresses the Catholic distrust of individualism and concern for institutional order.[64] Cognate terms such as *public good, public interest*, or *social welfare* are often used synonymously but arise from different philosophical parentage. Ideas about the common good divide sharply along the intellectual boundary fixed during the sixteenth and seventeenth centuries by philosophies of the Enlightenment.[65] The doctrine of the common good is the antithesis of Bentham's claim that the interest of the community is simply "the sum of the interests of the several members who compose it."[66] Rather, the common good insists on the conditions and institutions necessary for human cooperation and the achievement of shared objectives. These are decisive normative elements in the social situation, elements which individualism is both unable to account for in theory and likely to neglect in practice.[67]

8.2.2 The Common Good in the Tradition

Contemporary theological approaches to the common good have utilised the biblical witness.[68] Characteristic of Catholic interpretations of the biblical material is the emphasis placed on the communal and social dimensions of God's dealings with

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61 D. C. Maguire, *A New American Justice*, (Minneapolis: Winston Press, 1980), 86

62 Maguire, *A New American Justice*, 86

63 Nemetz, "Common Good" in *New Catholic Encyclopedia*, 19

64 J. Langan, "Common Good" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 102.

65 M. S. Copeland, "Reconsidering the Idea of the Common Good" in *Catholic Social Thought and the New World Order*, edited by O. F. Williams and J. W. Houck, (Notre Dame, Ind.: University of Notre Dame Press, 1993), 311

66 J. Bentham, *An Introduction to the Principles of Morals and Legislation*, edited by J.H. Burns and H.L.A. Hart, (London: Athlone Press, 1970), 12

67 Langan, "Common Good" in *A New Dictionary of Christian Ethics*, 102

68 Cf. U.S. Bishops, "Economic Justice for All: Catholic Social Teaching and the U.S. Economy", nn.30-55, *Origins* 16:24 (1986): 415-418

humanity. We are called to be a people and, when specific individuals in the biblical narratives are called, it is always for the sake of the people.[69] There is no doubt that a vision of the social order is at the very heart of biblical faith.[70] A communitarian ethic was at the heart of the religion of Israel. The good of the individual is always viewed in the context of the community.[71] The welfare of the community determined the welfare of the individual.[72] The community of Jesus' disciples continued the Lord's concern for the good of the entire community when it appointed deacons to care for the needs of widows in the early Church.[73]

Historically the notion of common good viewed the polis and the common as the sphere of human flourishing. The private domain was a zone of deprivation and incomplete humanity.[74] In the classical tradition, the common good was identified with the virtuous life lived and perfected within a just political community, or at least a community which self-consciously and self-critically praised, desired and sought virtue. In this tradition, politics is the continuation of ethics and finds its highest expression in a good and just life. The polis is not founded on self-preservation or self-regard, but on self-sacrifice, courage, moderation, on attachment to the common good.[75] On this view there is no opposition between the common good and the personal or individual good. The citizen found his own good (or end) in the good of the polis.

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69 M. J. Himes and K. R. Himes, "Original Sin and the Myth of Self-Interest" in *Fullness of Faith. The Public Significance of Theology*, (New York: Paulist Press, 1993), 39

70 J. J. Collins, "The Biblical Vision of the Common Good" in *The Common Good and U.S. Capitalism*, edited by O. F. Williams and J. W. Houck, (Lanham, Md.: University Press of America, 1987), 53

71 A greater focus on the individual and his or her individual and personal moral responsibility developed quite late in the history of Israel. Cf. Ez.18

72 Collins, "The Biblical Vision...," in *The Common Good...*, 59, 65

73 Ac.6:1-7

74 For a detailed history of the notion see R. Herzog, "Gemeinwohl" in *Historisches Worterbuch der Philosophie*, edited by J. Ritter, Vol. 3, (Darmstadt: Wissenschaftliche Buchgesellschaft, 1971), 248-58.

75 Jean B. Elshtain points to the "dark underside" of certain aspects of the communitarian tradition of common law in Western political thought. The "civic virtue" that has in fact historically moved people and nations to action has one glaring problem. It has frequently been "armed". There has been "a notable tendency to identify the common good with military victory, and *virtù* with military valor." Elshtain's approach focuses on a non-theological understanding of the common good. The Catholic tradition, it will be shown below, proposes a stringently theological understanding. D. Hollenbach, "The Common Good Revisited", *Theological Studies* 50 (1989): 75

For Augustine the "common good whose common pursuit knits men together into a *people*" applies to those who are subject to God and who live religiously.[76] The common good of the city of man is peace. This peace is to be judged by the divine law and thus it serves as a vehicle for the eternal life that is the end or purpose of the city of God. Because of Augustine's preoccupation with what is eternal and unchanging he had little interest in changing social conditions.[77] His appropriation and transposition of the classical understanding of the common good gave full weight to the dictates of divine revelation. In this way he extended the classical notion to encompass Christianity's promise of a supernatural destiny for each person. There was, however, crucial agreement between Graeco-Roman and Christian concepts regarding the common good:

> Each acknowledged the limitations, the finiteness of human nature and human existence; each assented to a standard independent of human will which might direct human beings toward an end, toward the perfection for which humans yearned.[78]

In elaborating his thinking on the *polis* Augustine challenged its supremacy as the domain of final human fulfillment. Another domain, the city of God, the heavenly Jerusalem, is the ultimate good of every person. This theocentric definition of the human good had a radical effect. It desacralised what the classical sources made holy, namely the *polis*. This required opposition to any ruler who claimed divine prerogatives. The final good of every person transcends any good that can be achieved politically, economically, or culturally.[79]

Augustine's deepest conviction was that human fulfillment would only be achieved in the communion of saints in the City of God. To make civil society the bearer of all one's hopes for happiness and justice was for him a form of idolatry.[80] A re-definition of the *res publica* provided the channel for radically redirecting the received notion of the common good. A people "is an assemblage of reasonable beings bound together by a common agreement as to the objects of their love."[81] In this guise the quality of a people's life will be directly proportional to the qualities of

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76 Augustine, *The City of God. Books XVII-XXII*, Bk.19, ch.24, in *The Fathers of the Church*, Vol. 24, (Washington, D.C.: Catholic University of America Press, 1954), 243-44

77 Nemetz, "Common Good" in *New Catholic Encyclopedia*, 16

78 Copeland, "Reconsidering...," in *Catholic Social Thought...*, 311

79 D. Hollenbach, "Common Good" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn.: The Liturgical Press, 1994), 194

80 "Augustine's rejection of the Greco-Roman ideal of the good of the polis or *civitas* as the highest human good 'marks the end of classical thought'." Hollenbach, "The Common...," *Theological Studies*, 81-82

81 Augustine, *City of God*, Bk.19, ch.24; cf. Hollenbach, "The Common...," *Theological Studies*, 83

the loves they share in common. Societies united by great and noble loves and dedicated to high standards of justice will be superior to those with lower goals and cultural values. This redefinition of what constitutes a commonwealth manifested a deep sensitivity to the ambiguities and tensions of political, ecclesiastical and terrestrial existence. Augustine did not identify civil society with Babylon or the *civitas terrena*, nor does he identify the Church with the *civitas Dei*. Within history the two cities are intermingled and interpenetrating, wheat and tares growing together:

> The interpenetration of the two cities in all zones of human life means that the Christian vision of the full human good - the kingdom of God - is no less relevant to the political sphere than it is to the life of the family or other forms of relationship. The full human good - the common good understood in its theological depth - cannot be realized in any one of these zones, including the Church.[82]

Thomas Aquinas concurred with Augustine in his stringently theological understanding of the common good.[83] For Thomas, the full common good is God's own self. Human beings achieve their ultimate fulfilment, their good, only by being united with God, a union that unites them to one another and indeed with the whole created order.[84] Everything human beings do in both personal and social life is directed to one end - union with the God who is their maker and redeeemer.

With Aristotle, Aquinas held that human beings are by nature social. Social community is an end of the common good. At one level, personal relationships such as associations, friendships and marriage contribute to this end.[85] A second level concerns the welfare of the wider social community as a political body. This end is realised through legislation. Human law is a dictate of practical reason for the common good and is framed either by the people as a whole or by the public official

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[82] Hollenbach, "The Common...," *Theological Studies*, 84. Jeffrey Stout has argued that the truth of the Augustinian vision of the two cities lies in the fact that no sphere of historical existence can rightly occupy the position of be-all-and-end-all in our lives, without throwing the rest out of proper proportion. Rather, each of the spheres in human living is a domain in which members of society find "some part of their identity" including that part that follows from being "citizens" of a republic dedicated to the common good. J. Stout, *Ethics after Babel: The Languages of Morals and their Discontents*, (Boston: Beacon Press, 1988), 235

[83] For outlines of the Thomistic synthesis see Copeland, "Reconsidering...," in *Catholic Social Thought...*, 312-313; L. S. Cahill, "Toward a Christian Theory of Human Rights", *Journal of Religious Ethics* 8:2 (1980): 282-283; R. A. Crofts, "The Common Good in the Political Theory of Thomas Aquinas", *The Thomist* 37 (1973): 155-73; G. Froelich, "Ultimate End and Common Good", *The Thomist* 57:4 (1993): 609-19; Nemetz, "Common Good" in *New Catholic Encyclopedia*, 15-19

[84] S.T.I-II, 19,10; cf. Hollenbach, "The Common...," *Theological Studies*, 81

[85] S.T. II-II, 152, 4; 153, 3; 154, 2

having this responsibility.[86] Law is ordered to the design of all that will assist persons to attain their happiness.[87]

Aquinas's discussion of the common good has a direct connection to his understanding of distributive justice.[88] As a general virtue justice directs a person in his or her relationship with others and with the social whole.[89] Justice is concrete rather than speculative. It governs actions. For Aquinas injustice is a special vice since it holds the common good in contempt and thus can lead to sin and the disruption of equality between people.[90] Thomas further distinguished between legal justice which directs a person to the common good and particular justice which governs the individual's relationship with others.[91] Two species of particular justice are detailed: commutative justice which is concerned with dealings between individuals and distributive justice which is directed to the proper and proportionate distribution of the common good.[92] Through legal justice individuals subordinate themselves to the common good. The common good is not equivalent to the individual's good, nor is it a collection or an arithmetical sum of individual or private goods. Such an idea is divisive and disruptive pitting one person against another. For Aquinas the common good is of a higher order.[93] The ultimate basis for an individual's participation in, claim on and duty to the common good is located in the fact that human beings are created by God. A help to understanding the common good is to be found in the universal goodness of God who, while transcending the universe, nurtures, sustains and embraces the whole and all its parts.[94] The theological virtues open a person to relate lovingly in the perfect society of the Trinity.

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86 S.T. I-II, 90,2, resp.; 90,3 resp.

87 S.T. I-II, 92,1, resp. and ad.1

88 Cf. S. J. Pope, "Aquinas on Almsgiving, Justice and Charity: An Interpretation and Reassessment." *Heythrop Journal* 32 (1991): 167-91

89 Justice is "a habit whereby a man renders to each one his due by constant and perpetual will." S.T.II-II, 58,1

90 S.T.II-II, 59,1

91 S.T.II-II, 58,6.; 58,7, ad.1 and ad.2

92 S.T.II-II, 61,1

93 S.T.II-II, 58,7, ad.2

94 Lisa Cahill sees the thomistic emphasis on "directedness to God" as the basis of what she calls "absolute duty". "The 'absolute duty' to seek this good [namely, God] could as well be understood as an 'absolute purpose', were it considered in its character as end or goal of human moral agency." She sees three corollaries related to this absolute obligation: (1) the response to the claim of God supersedes all temporal duties and finite claims; (2) the response of the person to God includes the actualisation and perfection of one's created and redeemed nature, i.e. the duty to be "virtuous" or to fulfill God's purposes; (3) the absolute obligation is the origin of all human rights. Cf. Cahill, "Toward a...," *Journal of Religious Ethics*, 283

By the middle of the eighteenth century the notion of the common good had been so transformed that it came to designate the aggregation of material goods. Nineteenth century political theory advanced the doctrine that the main business of government was to do for the multitude what no one citizen could do. This view is current in Australian public life. In reaction to the dominant social welfare agenda of governments since World War II present administrations proclaim a commitment to small government. Priority is given to limited corporate involvement in public life and to greater reliance on the individual.[95]

Among the tensions of life in contemporary pluralist democratic societies the issues of the common good are re-emerging in philosophical discourse.[96] Many are questioning the politics of self-interest that underpin national life today.[97] Michael Novak among others has argued that the best path to the common good in liberal democracies is not one that proceeds by intending the good of society as a whole but one in which an invisible hand guides the free market. Pursuit of individual self-interest is envisaged as maximising the social good.[98] An indicator of some of the complexities that arise from the liberal political tradition may be observed in Ronald Dworkin's discussion of what it means for a government to treat its citizens as equals. Dworkin argued that this question can be answered in two fundamentally different and opposed ways. The first rests on the conviction that equal treatment of

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95 "In our own time, politics has been reduced to the role of technical expertise in a utilitarian doctrine of prudence, the negotiation or adjudication of group or individual demands and rights. The modern version of the common good is 'surreptitiously reintroduce[d] in the form of 'those rules of the game' with which all conflicting groups are supposed to comply because those rules, reasonably fair to every group, can reasonably be admitted by every group.' The common good is manifest as an 'identity of interests', virtues are lowered to 'sentiments guided by corresponding moral principles' which bind persons together, and society is viewed as a 'cooperative venture for mutual advantage'." Copeland, "Reconsidering...," in *Catholic Social Thought...*, 315

96 Mainstream political philosophy is reconsidering the notion of the common good. Cf. W. Kymlicka, "Community" in *A Companion to Contemporary Political Philosophy*, edited by R.E. Goodin and P. Pettit, (Oxford: Blackwell, 1996), 366-378

97 Christiansen canvases the issues of liberalism in decline. Cf. D. Christiansen, "The Common Good and the Politics of Self-Interest: A Catholic Contribution to the Practice of Citizenship" in *Beyond Individualism. Toward a Retrieval of Moral Discourse in America*, edited by D. L. Gelpi, (Notre Dame, Ind.: University of Notre Dame Press, 1989), 58-60; see also R. N. Bellah, et al. *Habits of the Heart: Individualism and Commitment in American Life*, (New York: Harper & Row, 1986) and R. N. Bellah et al., eds., *The Good Society*, (New York: Alfred A. Knopf, 1991). The implications are explored from both Protestant and Catholic theological perspectives by G. J. Dorrien, *Reconstructing the Common Good*, (Maryknoll, N.Y.: Orbis Books, 1990)

98 M. Novak, "Free Persons and the Common Good" in *The Common Good and U.S. Capitalism*, edited by O. F. Williams and J. W. Houck, (Lanham, Md.: University Press of America, 1987), 222-43.; this article was later developed in book length form in which he sought to develop Maritain's basic thesis within an American capitalist and federalist framework: M. Novak, *Free Persons and the Common Good*, (Lanham, Md.: Madison Books, 1989)

citizens demands that "political decisions must be, so far as possible, independent of any particular conception of the good life."[99] Such a stand of *neutrality* is a necessary element in treating people equally because different persons in fact hold divergent understandings of the full human good. To favour one conception of the good over another is thus to favour some persons over others and to fail to treat them equally. The second response to the question of the meaning of equal treatment argues that it cannot be independent of some concept of the human good or the good life. "Treating a person as an equal means treating him the way the good or truly wise person would wish to be treated. Good government consists in fostering or at least recognizing good lives."[100] This *either/or* recalls the earlier discussion of liberal and communitarian notions of social life and indicates the wide gap between liberal estimations of public good and the Catholic tradition of the common good.[101]

8.2.3 Catholic Thinking on the Common Good in the Twentieth Century

Two strands of thinking appear to be present in current theological reflection on the common good. The first derives from the work of Augustine. The Augustinian approach shows that pursuit of the common good demands full respect for the many different forms of interrelationship and community in which human beings achieve their good in history. The common good is thus understood as a pluralistic ensemble of goods. None of these goods may be absolutised or allowed to dominate all the others. Each has a place within the framework of social existence, but this place cannot be determined by appealing to some absolute standard of goodness. In the Christian scheme the absolute is the heavenly Jerusalem, the City of God whose full realisation transcends history:

> Thus Augustine's thought provides a theological basis for affiming that the political domain has the potential to become a partial embodiment of the full human good. This opens up the possibility of a form of politics that seeks communitarian purposes. At the same time, the fact that politics can only hope to achieve part of the full human good means that it must necessarily be a pluralistic form of politics. And to the extent that it is pluralistic, it must respect many of the values and institutions of the liberal tradition.[102]

The Augustinian understanding of the meaning of the common good is thus *pluralistic-analogical.* It is pluralistic since the common good demands full respect

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[99] R. Dworkin, *A Matter of Principle*, (Cambridge, Mass.: Harvard University Press, 1985), 191

[100] Dworkin, *A Matter of Principle*, 191

[101] Cf. Hollenbach, "The Common...," *Theological Studies*, 76-79

[102] Hollenbach, "The Common...," *Theological Studies*, 85

for the many different forms of interpersonal and social relationships in which human beings achieve their good in history. The temporal good is therefore a rich ensemble of goods. Each of them has a place within the framework of social existence, but none may be absolutised or allowed to dominate all others. It is analogical because the good achieved in the communal relationships of family, friendship, civil society, or politics is a genuine, but partial reflection of the full common good achieved in the communion of the kingdom of God.[103]

The second strand of reflection originates with Thomas Aquinas. Thomist readings of the common good which have greatly influenced Catholic social teachings this century have generally diverged over whether the common good in politics may be interpreted in personalist or corporate terms. Does the common good regard the individual as a person with an irreducible dignity which entails certain forms of respect, or does it treat the individual simply as a member (part) of the body politic? Thomas himself seems to have done both. He opposed the common good, on the one hand, to the private good of an individual or faction and, on the the other hand, to the good of persons. In the first case, the common good, that is the good of the whole community, took piority over individual good, the welfare of society over the individual. In this view the individual belonged to a larger social body and the good of the whole took precedence over individual goods. This implies that individual self-interest should take a back seat to the general welfare. Giving priority to the common good warrants sacrificing one's life in defense of one's homeland. In the second view, however, the human person is preeminent. In Thomas's mind, as a *person* the individual human being is ordered directly to God and as such exceeds the political community in worth. The distinction between *individual* and *person* served to justify in a single system the differences between the older collectivist feudal model of society, on the one hand, and the emerging freedom of urban society on the other.

Twentieth-century Thomists have employed the good of the person to defend the values of human dignity and universal human rights. In this sense human rights, as features of the person, remained in tension with the common good as the collective welfare of the community.[104] During the 1940s Jacques Maritain developed Catholic thinking on the common good with his particular brand of personalist-communitarianism. Its central anthropological affirmation was "that personality

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[103] Hollenbach, "Common Good" in *The New Dictionary of Catholic Social Thought*, 195

[104] D. Christiansen, "The Common Good and the Politics of Self-Interest...," in *Beyond Individualism*, 61

tends by nature to communion".[105] Human beings are by nature ordained to life in society, to life in relation to other persons. This is so for two reasons. First, persons relate to one another whereas subpersonal beings merely exist in spacial juxtaposition to each other. They cannot form communities, but only physical collectivities. The capacity for community is a positive perfection of personality. For this reason the dignity of person can be realised only in community. Genuine community can exist only where the dignity of persons is secured. Personhood and community are mutually implicating realities. Second, humans are social for a negative reason. As finite and limited persons human beings have needs and deficiencies as well as positive capacities for relationship. They need other persons and the larger society in order to thrive and exist. These needs are material (such as for food or shelter) and of a higher order (moral and intellectual education). At the most fundamental level we need God to sustain our very existence and as the fulfillment of our capacity for relationship.

This twofold foundation of human sociality was the basis of Maritain's understanding of the analogical nature of the common good. The central theological root of Maritain's discussion of the relation between the person and the common good is that "the idea of the person is an analogical idea which is realized fully and absolutely only in its supreme analogue, God."[106] Maritain located humans on an analogical scale between the Trinity and animals. "In the society of persons that is the Trinity, each one is in the other through an infinite communion."[107] Nonhuman animals have no such capacity for communion, and in this sense have no common good properly speaking. Human society is located between these two. A society of persons who are material individuals and for that reason isolated each within himself or herself, nevertheless requires communion with one another in this world. This anticipates the perfect communion with one another and God in life eternal.[108]

Human beings are destined to a good which is beyond both civil society and the state. Both society and the state have an obligation to respect this transcendence of the human person. Thus the theological framework of Maritain's discussion of the common good leads immediately to a theological warrant for many liberal values and

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[105] J. Maritain, *The Person and the Common Good*, (Notre Dame, Ind.: University of Notre Dame Press, 1972), 47. For an excellent survey of the theological debate provoked by Maritain's thought see R. McInerny, "The Primacy of the Common Good" in *The Common Good and U.S. Capitalism*, edited by O. F. Williams and J. W. Houck, (Lanham, Md.: University Press of America, 1987), 70-83.

[106] Maritain, *The Person and the Common Good*, 56

[107] Maritain, *The Person and the Common Good*, 58

[108] Maritain, *The Person and the Common Good*, 59

institutions. Maritain, however, carefully distinguished his personalist interpretation of these values from individualism. The freedom and dignity of persons are achived in communal relationship with other persons, not in isolation. Thus respect for this freedom and dignity calls for respect for the many forms of relationship in which persons can participate (friendships, family, civil society). Each of these relationships realises a part of the terrestrial common good. Each is analogous to the ultimate common good, that is the union of human beings with God and with one another in God.[109]

Vatican II distinguished, as noted earlier in chapter 6, between *person* and *common good* in its justification of religious liberty.[110] Furthermore, *Dignitatis humanae* contains the clearest discussion in recent official teaching on the way government contributes to the common good. The document maintained that all civil society, in its communal plurality, is responsible for building up the common good. The state is charged with the protection of *public order*:

> Public order is itself a moral concept: it is that basic degree of social union that is necessary for a genuinely civil society to exist at all. There are three prerequisites for such union: justice (which secures for people what is due them, namely their human rights); public peace (which will only be genuine peace when it is founded on justice); and public morality (the standards of public behavior on which consensus exists in society).[111]

Government, therefore, does not have the responsibility for promoting the full common good of the people for to do so would lead to massive intervention in all spheres of civil life.[112] Each sector of the society has its own proper contribution to

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[109] Hollenbach, "The Common...," *Theological Studies*, 87

[110] *Dignitatis humanae*, n.2 in Flannery, *Vatican Council II*, 800-801

[111] Hollenbach, "Common Good" in *The New Dictionary of Catholic Social Thought*, 196; cf. *Dignitatis humanae*, n.7 in Flannery, *Vatican Council II*, 804-805

[112] The two principles of *subsidiarity* and *solidarity* play an important role in Roman Catholic social theory. The former governs the role and activity of the state. The state exists as a help (*subsidium*) for individuals and the lesser associations, bodies and institutions in society. In all of this, however, the "social order and its development must constantly yield to the good of the person, since the order of things must be subordinate to the order of persons and not the other way around." *Gaudium et spes*, n.26 in Flannery, *Vatican Council II*, 927. This line of thinking does not justify the notion that "the government that governs least governs best." Rather it defines good government intervention as that which truly *helps* other social groups contribute to the common good by directing, urging, restraining and regulating economic activity as the occasion requires and necessity demands. U.S. Bishops, "Economic Justice for All...," n.124, *Origins* 16:24 (1986): 425; see also nn.312-321, *ibid.*, 442-443. For a succinct exposition of the principle in its earlier and later forms see D. Dorr, *The Social Justice Agenda: Justice, Ecology, Power and the Church*, (Melbourne: Collins Dove, 1991), 88-90. See also Cf. R. A. McCormick, "Moral Theology in the Year 2000" in *Corrective Vision: Explorations in Moral Theology*, (Kansas City, Mo.: Sheed & Ward, 1994), 30-33; J. Beyer, "'Principe de subsidiarité' ou 'juste autonomie' dans l'Eglise", *Nouvelle Revue Theologique* 108 (1986): 801-22; J. Beyer, "Le

make to the common good and government must respect and encourage these contributions. Government, however, is responsible for the achievement of that part of the common good that enables society to function as a community of citizens. The U.S. bishops developed this understanding when they defined human rights as "the minimum conditions for life in community".[113] Pursuit of the common good and protection of human rights are thus complementary practical objectives.[114]

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principe de subsidiarité: Son application en Eglise", *Gregorianum* 69:3 (1988): 435-59. Grisez, *The Way of the Lord Jesus*, Vol. 2, 357-359; I. Schasching, "Das Subsidiaritatsprinzip in der Soziallehre der Kirche", *Gregorianum* 69:3 (1988): 413-33; G. Grima, "Sussidiarietà" in *Dizionario di Bioetica*, edited by S. Leone and S. Privitera, (Acireale: EDB-ISB, 1994), 967-70. The term *solidarity* denotes the common interests uniting a group or nation. It was borrowed by Catholic social theorists from labour union movements as a means of differentiating Catholic social teaching from twentieth century liberalism and communism. Cf. M. L. Lamb, "Solidarity" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn: The Liturgical Press, 1994), 908. In *Sollicitudo rei socialis* Pope John Paul II has called attention to the structure of interdependence in human existence and has focused on the *virtue of solidarity* which is not a vague feeling of compassion but "a firm and persevering determination to commit oneself to the common good"(nn.39-40). Catholic teaching on solidarity has been primarily pastoral in scope. Cf. Mt.25:31-46; B. V. Johnstone, "Solidarity and Moral Conscience: Challenges for Our Theological and Pastoral Work", *Studia Moralia* 31 (1993): 67. Sally McFague, adopting an ecological perspective, sees Christian solidarity with the oppressed as going beyond human beings to include all life-forms. She sees this as "a democratizing tendency that counters the fang and claw of genetic evolution as well as its two basic movers, chance and law." S. McFague, *The Body of God. An Ecological Theology*, (Minneapolis: Fortress Press, 1993), 171

113 John XXIII had defined the common good as "the sum total of the conditions of social living." *Mater et Magistra*, n.65 in *The Gospel of Peace*, 157. This is quoted in *Pacem in terris*, n.58 and later in *Gaudium et spes*, n.26. In C. E. Curran, "Official Catholic Social Teaching and the Common Good" in *Tensions in Moral Theory*, (Notre Dame, Ind.: University of Notre Dame Press, 1988), 128-133 the author maps the continuities and discontinuities of recent official Catholic social teaching in regard to the common good. Among the changes to the content of the common good he notes the shift in analysis from Church-state to Church-society, focus on the areas for lesser and greater roles for government in social issues, the common good and public order, the international dimension of the common good, focus on personalism, human rights, equality and an acceptance of a conflictual model of society.

114 Drew Christiansen argues that it is possible to "make a case that conceiving of the common good as the general enjoyment of human rights in society offers a more comprehensive, accurate, and definitive understanding of the common good than the customary appeal to 'conditions of social living'." Christiansen, "The Common Good...," in *Beyond Individualism*, 63. Two further advances in understanding the common good in magisterial teaching should be noted here. The first is an appreciation that the common good is an increasingly trans-national or international reality. John XXIII: *Pacem in terris*, nn.134-135; Paul VI: *Populorum progressio*, nn.43ff. in *The Gospel of Peace*, 229, 400ff.; John Paul II: *Sollicitudo rei socialis*, n.36 in *Encyclical Letter 'Sollicitudo rei socialis'*, (Homebush NSW: St. Paul Publications, 1988), 76-79 argued that the rivalry between the Eastern and Western blocs in world politics during the Cold War was the principal impediment to the achievement of the international common good and greater global solidarity. The second is to be found in John Paul II's call to include the good of the biosphere in the understanding of the common good. *Sollicitudo rei socialis*, n.34 in *Encyclical Letter...*, 73-74; cf. Hollenbach, "Common Good" in *The New Dictionary of Catholic Social Thought*, 196-197.

The *social conditions* approach to the common good introduced by Pope John XXIII in *Mater et magistra* indicated three important perspectives. First, the provision of the conditions of social living necessitates guaranteeing the resources, defending the liberties, relieving the impediments, and opening the opportunities for citizens to participate fully in their society.[115] The *principle of participation* in recent Catholic teaching flows from this ideal of social living. Second, the goal of the common good is that men and women be "enabled more fully and more readily to achieve their own perfection".[116] The traditional understanding of the common good prized human flourishing. The common aim is for humans to flourish. Third, the definition of common good in terms of the "conditions of social living" suggests an evolving standard of well-being. It appeals, not to any absolute level of entitlement, but rather to those standards which enable people to develop more fully and more readily. It does not invoke a basic needs standard, though basic needs would represent an absolute minimum as the condition for development.[117] As social conditions evolve so do the common possibilities of members of that society. Social responsibility, the sense of the common good, demands that everyone enjoy the benefits of an improved quality of life.[118]

In his analysis of developments in recent Catholic social teaching the American moralist, Charles Curran, has observed that priority has been given to three

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[115] The Australian bishops followed this approach in their wealth inquiry. Australian Catholic Bishops' Conference, *Common Wealth for the Common Good. A Statement on the Distribution of Wealth in Australia*, (North Blackburn, Vic.: Collins Dove, 1992), 18-19, 29. For a description of the inquiry see M. Hogan, *Australian Catholics: The Social Justice Tradition*, (North Blackburn, Vic.: Collins Dove, 1993), 125-133

[116] Paul VI in *Populorum progressio* used the term *development* to refer to the same goals and processes that John referred to as *perfection.*

[117] Leo XIII in *Rerum novarum* articulated the criterion of "a decent family living" for evaluating wages of workers. John XXIII adopted an optimistic view that an increasingly complex society with its institutions and social conditions would make a better standard of living possible for everyone. *Mater et magistra,* nn.46-49; 54; 61-63 in *The Gospel of Peace*, 152-153, 154-155, 156-157

[118] In the earlier social encyclicals of Leo XIII and Pius XI the defence of the rights of workers and the poor was carried out with an assumption that different standards of living were appropriate to people in different roles either because of social status (Leo) or social function (Pius). John XXIII rejected these assumptions. Inequities of class were viewed by him as incompatible with the common good. Cf. *Mater et magistra,* nn.74, 79 in *The Gospel of Peace*, 159-160. In *Pacem in terris* he moved beyond the analysis of socioeconomic development found in his earlier letter to an explicit consideration of human rights. "In identifying the growth of socio-economic inequality as the source of rights violations John had identified a sign of the time which would appear over and over again in later years in the social teaching of the Council, of Pope Paul VI, and of Pope John Paul II." Christiansen, "The Common Good...," in *Beyond Individualism*, 68. The common good, therefore, entails a norm of relative equality because when inequalities go unchecked it becomes difficult, if not impossible, to guarantee even basic rights. Cf. D. Christiansen, "On Relative Equality: Catholic Egalitarianism after Vatican II", *Theological Studies* 45 (1984): 651-75.

dimensions of the human person: freedom, equality and participation. This advance has effectively contributed to a new understanding of society as pluralist, rights-based and respectful of subsidiarity. A renewed appreciation of the common good has followed .[119]

Currently Catholic theologians in the English speaking world are engaging the issues of the common good.[120] Even within liberation theology there is evidence of an attempt to grapple with the issue even though this group of theologians has, in the past, vigorously criticised the natural law tradition which underpins thinking on the common good.[121]

In North America Dennis McCann has, in a number of recent works, taken up the question of how society or the Church might discern what the common good requires. He has argued that public discussion to determine *generalisable interests* provides the best way to identify the moral requirements of the common good. A generalisable interest

> indicates the community's intention of shaping a public consensus regarding society's *needs* and *norms*, which will then frame the discussion of policy but not preempt it. Precisely because it is perspectival, and therefore provisional, it may also be generalizable: it all depends on how consensus emerges from the public argument that it succeeds in provoking.[122]

McCann has proposed that the common good should be defined as *the good to be pursued in common.* In this he is "advocating a deliberate break with the traditional Catholic *social doctrine* that assumes the common good to be substantive,

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119 C. E. Curran, "Official Catholic Social Teaching and the Common Good" in *Tensions in Moral Theory*, (Notre Dame, Ind.: University of Notre Dame Press, 1988), 123; cf. M. J. Himes and K. R. Himes, "Original Sin and the Myth of Self-Interest" in *Fullness of Faith. The Public Significance of Theology*, (New York: Paulist Press, 1993), 39-41. It is important to note that John Paul II characterises impediments to the common good in terms of *structures of sin.* He sees this as particularly significant as structures of sin have a negative impact on the economic prospects of developing countries. Cf. *Sollicitudo rei socialis*, n.36 in *Encyclical Letter...*, 76-79. For a critique of this conceptualisation see J. Langan, "Personal Responsibility and the Common Good in John Paul II" in *Ethics, Religion, and the Good Society. New Directions in a Pluralist World*, edited by J. Runzo, (Louisville, Ky.: Westminster/John Knox Press, 1992), 132-47.

120 Cf. O. F. Williams and J. W. Houck, eds., *The Common Good and U.S. Capitalism*, (Lanham, Md.: University Press of America, 1987); Grisez, *The Way of the Lord Jesus*, Vol. 2, 332-347

121 Cf. the work of Ignacio Ellacuria analysed in T. L. Schubeck, "The Reconstruction of Natural Law Reasoning. Liberation Theology as a Case Study", *Journal of Religious Ethics* 20:1 (1992): 165-178

122 D. P. McCann, "The Good to be Pursued in Common" in *The Common Good and U.S. Capitalism*, edited by O. F. Williams and J. W. Houck, (Lanham, Md.: University Press of America, 1987), 176-177

objectively knowable and indivisible."[123] His rephrasing suggests that the common good needs to be understood in procedural as well as substantive terms. In other words, the principle of the common good does not offer an already-out-there, ready-to-be-grasped norm of justice but rather a set of goals to be arrived at through open debate and public consensus. McCann is thought to be making an important contribution to Catholic theology by suggesting that public dialogue plays an essential role in identifying the common good. [124]

8.3 JUSTICE AS PREFERENTIAL OPTION FOR THE POOR

Catholic social teaching, as noted earlier, is grounded in three basic affirmations: (1) the inviolable dignity of the human person, (2) the essentially social nature of human beings, (3) the belief that the abundance of nature and of social living is given for all people. Justice, in this tradition, is not simply a matter of proper distribution of goods but also of permitting and indeed requiring each person to participate in the production of these goods. The vision of justice is a vision grounded in a sense of solidarity, mutual responsibility, and joint benefit. Individual rights and the common good are never in opposition to each other but are mutually supporting basic principles. Reason and revelation are the mutually supporting sources of this justice insight.[125]

The evolution of Catholic thinking on justice has at times been slow and faltering. In fact the manuals that dominated moral theology for the period from 1850 to 1970 have been criticised for the way they studied justice.[126] Justice was treated in the manuals as little more than a course in natural law. Part of the failure can be traced to Aquinas, who adopted Aristotle's understanding of justice but did not relate it to his own theological analysis of charity. Furthermore, the justice tract in Catholic moral theology depended heavily on law, glorifying it as the criterion of justice. Aquinas, in fact, viewed justice and law in the same light. Just as the role of justice is to

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[123] McCann, "The Good...," in *The Common Good and U.S. Capitalism*, 166

[124] Cf. Christiansen, "The Common Good...," in *Beyond Individualism*, 74

[125] Cf. K. Lebacqz, *Six Theories of Justice*, (Minneapolis: Augsburg, 1986), 67, 71

[126] Cf. D. O'Callaghan, "The Meaning of Justice" in *Moral Theology Renewed*, edited by E. McDonagh, (Dublin: Gill & Son, 1966), 169-172; A similar critique of modern philosophical attention to justice has been offered by Forrester when he considers the assumptions implicit in the proposals of Nozick, Rawls, Ackerman and Hayek. Cf. D. B. Forrester, "Political Justice and Christian Theology", *Studies in Christian Ethics* 3:1 (1990): 1-13. Stanley Hauerwas takes a similarly critical view of philosophical efforts regarding justice. Cf. S. Hauerwas, *After Christendom? How the Church is to Behave if Freedom, Justice, and a Christian Nation are Bad Ideas*, (Nashville, Tn.: Abingdon Press, 1991), 45-68

introduce order and reason into human affairs, so too with law.[127] This legalistic bias was reinforced by two other factors. First, canon law had become increasingly legalistic as a result of the influence of Nominalism. Second, casuistry, especially during the seventeenth to nineteenth centuries, intensified a preoccupation with the law. Together these influences reinforced the role of natural law thinking in Roman Catholic ethics.

Fundamental and social reflection in Roman Catholic moral theory have, in recent times, moved away from a traditional natural law methodology at a time when Catholic justice thinking is engaged in a wide range of contemporary issues. Among these are questions such as the gap between rich and poor, international debt, oppression and liberation, violence and non-violence, disarmament, justice for women, racism, human rights, world population, ecology, refugees and unemployment, to name but a few.[128] This varied spectrum of issues has contributed to a vibrant theological analysis of justice issues in Roman Catholic moral theology.[129] In this section attention will be given to the underlying concept of justice that permeates much Catholic theology and praxis.[130] The analysis will proceed in four steps. Following a consideration of the essential components of justice as it has been considered down through history the focus will then shift to the specifically theological dimensions of justice that have evolved in recent Roman Catholic thinking. It is against this background that the notion of justice as preferential option for the poor will be considered. Finally, a brief discussion of justice and health care in Catholic moral theological literature will link this section on justice to the central theme of this thesis.

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127 S.T. II-II, 123,12: "Ad ipsam (justitiam) pertinet ordinem rationis ponere in omnibus rebus humanis." and S.T. I-II, 90,4: "Lex est quaedam rationis ordinatio ad bonum commune."

128 Dorr, *The Social Justice Agenda*, 7-41; for a brief survey of fourteen key areas of Catholic social justice thinking and the development that has occurred in each area see *ibid.*, 83-102

129 For traditional Catholic moral theological analyses of justice see B. Haring, "Justice" in *Law of Christ*, Vol. 3, (Cork: The Mercier Press, 1967), 22-34.; M. Cozzoli, "Giustizia" in *Nuovo Dizionario di Teologia Morale*, edited by F. Compagnoni, G. Piana, and S. Privitera, (Milano: Edizioni Paoline, 1990), 498-517.; E. Welty, *A Handbook of Christian Social Ethics*, (Herder: Frieburg, 1960), 281-324; Grisez, *The Way of the Lord Jesus*, Vol. 2, 320-332. For primarily philosophical texts see J. Pieper, *The Four Cardinal Virtues*, (Notre Dame, Ind.: University of Notre Dame Press, 1975), 43-113; O. Blanchette, *For a Fundamental Social Ethic: a Philosophy of Social Change*, (New York: Philosophical Library, 1973), 75-111

130 For a brief outline of twelve major themes of justice in the tradition see Henriot, DeBerri and M. J. Schultheis, *Catholic Social Teaching*, 20-22

8.3.1 Justice

Justice regulates relationships between strangers. Where there is perfect love and communion, the question of rights and duties becomes moot; they are completely fulfilled. Justice, therefore, mediates between the otherness which arises from our exterior bodily character as human beings and the oneness which arises from our interior, spiritual qualities.[131] Often the term *righteousness* is used interchangeably with *justice* especially in theological writing. The most general meaning of righteousness is uprightness, rectitude, or justice, and the word may be applied to God or to humans.[132]

Fundamentally, justice is about duties and responsibilities, about building the good community.[133] "Justice is the moral virtue which inclines one to respect man's personality and to grant him what is due to him as an individual charged with the responsibility of his own destiny."[134] When men are friends, Aristotle taught, they have no need of justice. Both justice and friendship for Thomas Aquinas are forms of sharing. Justice points to friendship, it is incipient friendship.[135] Justice is the least we can do in response to the value of persons. It is love in embryonic form. When this justice-love matures, it moves beyond a concern for rights and obligations and is transformed into the superior dynamism of love, friendship and community. Community is friendship at a societal level. Since love is not yet fully realised in society, justice presents itself as the minimal expression of moral sentiment. Furthermore, justice as the first expression of our response to the value of persons recognises that their value is such that they may lay claims on us. Justice is the first of many virtues telling us how we should respond to persons in view of who and what they are.[136]

From a humanist perspective justice is viewed as a principle of order and coexistence.[137] It satisfies the legitimate demands of individuals and community. At

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[131] McBrien, *Catholicism*, revised ed., 944

[132] J. Childress, "Righteousness" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 556

[133] Keane, *Health Care Reform*, 134; cf. *Catechism of the Catholic Church*, n.1807

[134] O'Callaghan, "The Meaning…," in *Moral Theology Renewed*, 159

[135] D. C. Maguire and A. N. Fargnoli, *On Moral Grounds: The Art/Science of Ethics*, (New York: Crossroad, 1991), 32

[136] Maguire and Fargnoli, *On Moral Grounds*, 28-29

[137] Hauerwas argues that no discussion of justice by Christians can ignore Michael Ignatieff's *The Needs of Strangers* in which he argues that the problem with most contemporary political philosophies is not that they are individualistic, but that in the absence of any account of the good, individuals are led to believe that all their needs are legitimate. Justice, thus construed,

the personal level justice exacts respect for a person's individuality. It recognises independence, protects from arbitrary interference, guarantees security and the liberty to live one's own life and to do as one wishes with what one has. At the community level justice promotes order and tranquillity by delineating the spheres of influence of the various individual and social units in society. It prevents clashes that inevitably occur if everyone simply acts with their own ends always in view. In the nature of things justice and law are inseparable.[138] Justice, in this account, is benign but it can be used to vindicate rights without mercy. This dark side of justice is manifest in the blind instinctive justice of the vendetta.[139] This is the justice of the mythical *Dike*, blind-folded, sword in hand, balancing debt and payment with inexorable rigour.[140] Justice as *dike* when applied to the juridical and administrative aspects of social life may mean (1) the egalitarian order that ought to be established in a normal society, (2) the complex of laws guaranteeing that same order; or (3) the organ or regime that, without discrimination or favoritism, applies these laws equally to all.[141]

Aristotle distinguished general or legal justice from particular justice. The former is closer in meaning to righteousness in human relations, the latter he divided into commutative and distributive justice.[142] The word justice refers to several distinct realities. It may refer to an objective situation or to a state of affairs involving either an action affecting others or an interpersonal relationship that is as it ought to be.[143] Justice pertains also to certain morally good human acts. The term *just* refers to the moral quality of a good choice or act which bears on another and effects a just state of affairs. A third sense of justice applies to the character of certain persons. A person is just when his or her choices and actions have formed a character that

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leads to efforts to create societies that are free of constraints upon the needs of its members. S. Hauerwas, *After Christendom? How the Church is to Behave if Freedom, Justice, and a Christian Nation are Bad Ideas*, (Nashville, Tn.: Abingdon Press, 1991), 61

138 O'Callaghan, "The Meaning...," in *Moral Theology Renewed*, 166

139 The *lex talionis* based on "an eye for an eye" (Ex.21:24-25)

140 Justice is derived from *dike*, i.e. directive, indication, order. Dike is the daughter of Zeus and shares in his governance of the world. The *dike* is necessary, according to the Greeks, so that people may develop a personal and communal life in an ordered manner.

141 The opposite to juridical and administrative order is *bie*, violence, or power destructive of order. I. Fucek, "Justice" in *Dictionary of Fundamental Theology*, edited by R. Latourelle and R. Fisichella, (New York: Crossroad, 1994), 568-569

142 *Nic.Eth.* V.2.12 in *Aristotle. XIX The Nicomachean Ethics*, English translation by H. Rackham, (Cambridge, Mass.: Harvard University Press, 1975), 267; see also Aquinas: S.T. II-II,61,2. W. Werpehowski, "Justice" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 329-330

143 S.T.II-II, 57,1; "The stolen property has been restored and the thief tried and punished, so justice has been done." The four divisions used here are adopted from Grisez, *The Way of the Lord Jesus*, Vol. 2, 320-321

disposes the agent to further just choices and actions. In a fourth sense *just* refers to the quality of interpersonal relationships that contribute to an harmonious community. Justice is found in a community which has structured itself through laws, practices and institutions such that they embody the justice of the citizenry.

Justice, in analysis through the centuries, has been considered to have three essential elements: (1) reference to another, (2) the satisfaction of the other's strict right and (3) the equality produced. These elements are intimately connected and a proper appreciation of any one necessarily introduces the other two.[144] A brief consideration of these aspects is helpful for what follows. First, the *otherness* of justice. Relation to the other is a distinctive characteristic of justice. Justice orders the individual in his or her dealings with others. Essential to every form of justice is this inter-subjectivity, the fact that it interrelates two or more individuals by means of some external contact or transaction. Justice is always a community virtue, it is always possessed of a social, outward-looking note in that it commands respect for the right of others.

Second, the notion of a *right* is integral to justice. In justice an individual claims his *right* (*ius, debitum*). He claims something which belongs to him in such a way that everyone, whether private individual or public authority, must grant it to him and allow him to enjoy it.[145] Since it is the function of justice to respect and to grant a right, the notion of right precedes and specifies the notion of justice.[146] Creation establishes the basis of rights.[147] The human being is the subject of rights because he or she is created by God and is thus responsible for his or her own destiny. Therefore, certain things and opportunities are due which can be claimed from others as the necessary means for human development and the attainment of one's final end. The world, society, and civilisation have no other immediate meaning than to serve the human being. The duties of justice are a necessary consequence of the human being's personality and individuality. If justice is downgraded an attack occurs not not only against the material order but against the independence of the human person.

The object of justice is not merely a moral duty (*debitum morale*) but entails also a legal obligation (*debitum legale*). The individual owed a *debitum* has a strict title to it

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144 Cf. O'Callaghan, "The Meaning...," in *Moral Theology Renewed*, 155-160

145 "Ratio vero justitiae consistit in hoc quod alteri reddatur quod ei debetur secundum aequalitatem." (S.T. II-II,80, 1)

146 "[i]f the act of justice is to give each one his due, then the act of justice is preceded by the act whereby something becomes his due." Aquinas: *Summa contra gentiles*, 2,28

147 The same point had been made by Cicero: "Natura iuris....ab hominis repetenda est natura", *De Legibus*, 5:17

and he can vindicate it as his right against all comers.[148] It is important to note here that St. Thomas followed the Greeks and Romans in using *ius*, or right, in its objective sense to denote that which is owed. Modern theologians frequently apply it in a subjective sense indicating the moral faculty by which a person appropriates and controls particular objects.[149] Although distinct the two meanings are intimately connected.[150] The subjective sense is the more fundamental and is logically prior. The only reason why a given thing or action is a *ius* or *debitum* in the objective sense, is that a certain person has a right to demand or possess it. It is due to him because it is bound to him by some title which gives him an exclusive claim on it. The ultimate reason for an obligation in justice will be found not by analysing the matter but by examining the subject. If we wish to determine whether a given thing is a matter of justice we look to the title of the claimant. Such title may derive from human nature (the right to life), from a just law (a prohibition) or from some contingent fact (contract, injury). On the basis of these titles one can claim something as one's own.[151]

The third essential element of justice is *equality*.[152] Such equality is established in a two-fold way. First, *commutative* justice governs the relations between individuals. It commands each to respect the right of the other, to refrain from undue interference, to honour contracts, to repair injuries. This is the justice of arithmetical equality in

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[148] "Debitum quidem legale est ad quod reddendum aliquis lege adstringitur; et tale debitum proprie attendit justitia, quae est principalis virtus. Debitum autem morale est quod aliquis debet ex honestate virtutis." (S.T., II-II, 80, un)

[149] It is claimed that the authority of Suarez's *De Legibus* was in large measure responsible for the general acceptance of the subjective dimension of *ius*. Cf. O'Callaghan, "The Meaning...," in *Moral Theology Renewed*, 158, note 25. Historians of canon law argue that the concept of subjective rights has its origins in the canon law of the 12th and 13th centuries. Cf. C.J. Reid, "Thirteenth-Century Canon Law and Rights: The Word 'ius' and Its Range of Subjective Meanings", *Studia Canonica*, 30:2 (1996):299

[150] There is an ambiguity in the notion of justice as *receiving what is due to one*, at least as it pertains to distributive justice. It may pertain to enjoying or undergoing (a) *what someone has an obligation to render to one* or (b) *that to which one has a legitimate claim*. In the second sense justice is the same as enjoying one's rights, "since to have a right to something, in at least one important sense of the phrase 'to have a right', is to have a legitimate claim to that something." N. P. Wolterstorff, "Justice and Peace" in *New Dictionary of Christian Ethics and Pastoral Theology*, edited by D. J. Atkinson and D. H. Field, (Leicester: Inter-Varsity Press, 1995), 16

[151] O'Callaghan, "The Meaning...," in *Moral Theology Renewed*, 158. Note that this personal or subjective approach is a corrective to the material notion of justice found in Ulpian's classical definition: "constans et perpetua voluntas ius suum cuique tribuendi". The concept implicit in the idea of handing over something suggests that justice governs mere transactions in external goods, whereas justice exercises its most important function in protecting the human rights to life, to integrity, to freedoms of one kind or another.

[152] S.T., I-II, 114, 1c: "Justitia autem aequalitatis quaedam est."

which the parties encounter one another on an equal footing.[153] Commutative justice is thus an expression in the sphere of private interaction of both the genuine dignity of all persons and the need for a mutuality based on equality in their relationships and agreements.[154] Second, *distributive* justice demands that a fair distribution of the goods and burdens of society be made to all members on a proportional basis. As one's contribution to the economy is greater one has a right to a greater return; as one's need is more urgent one has a right to greater assistance; as one possesses more wealth one is obliged to bear heavier taxes. Beforehand no one has a strict right to any given benefit or service, but all have a right to demand that the correct order be observed in the distribution of benefits and obligations. This must be the guiding principle of the executive authority of the state or the bureaucracy that administers the laws of public assistance, grants, taxes and the rest.[155]

Both commutative and distributive justice realise in their own way the three essential qualities of justice outlined above. Distributive justice, however, falls short of the perfect verification of justice found in commutative justice.[156] In distributive justice the two persons involved are not adequately distinct since the individual does not have the same strict right to what is owed as in the case of commutative justice. In the latter case the thing owed truly already belongs to the individual with the claim. What is owed in distributive justice is not determined according to strict arithmetic equality but according to geometric or proportional equality. Distributive justice is not determined merely by things themselves but necessarily and intrinsically involves a consideration of the person. Distributive justice is not blind justice for it must take the person into account. Distributive justice directs the relationship of the social whole in the distribution of the goods and burdens that are part of communal existence in human society and in the state. The most general criterion governing distribution is that goods or benefits are to be distributed according to needs, burdens according to capacities.[157]

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[153] O'Callaghan, "The Meaning…," in *Moral Theology Renewed*, 161; cf. *Catechism of the Catholic Church*, n.2411

[154] D. Hollenbach, "Modern Catholic Teachings Concerning Justice" in *Justice, Peace, and Human Rights. American Catholic Social Ethics in a Pluralistic World*, (New York: Crossroad, 1988), 26

[155] O'Callaghan, "The Meaning…," in *Moral Theology Renewed*, 161; cf. Hollenbach, "Modern Catholic...," in *Justice, Peace, and Human Rights*, 26-27

[156] In Catholic moral theology distributive justice was downgraded by many theologians following the lead of Billuart who compared it unfavourably with commutative justice. See his *Comment. in Summam S. Thomae*, tom.6, disp.8, art.1, par.14

[157] C. E. Curran, "Just Taxation in the Roman Catholic Tradition", *Journal of Religious Ethics* 13:1 (1985): 120

Implicit in any discussion of distributive justice, at least within the Catholic tradition, is an understanding of the social destiny of the goods of creation.[158] For this reason distributive justice must recognise the need of human beings to have what is necessary to live a minimally decent human life. Human needs thus give a right to this basic floor. There are other aspects, however, which enter into the wider question concerning the total distribution of the goods of creation. For the last century the Catholic Church's social teaching has walked a middle road between individualism and collectivism. In the consideration of distributive justice the teaching has repeatedly recognised the need for a basic minimum for all, but beyond that has allowed for inequality. Curran judges that if anything:

> the Catholic tradition could be criticized for not spelling out in greater detail how and why such differences can be allowed above and beyond the basic minimum. Distributive justice consequently differs from equalitarian justice precisely because it does not demand total equality in external goods.[159]

While present Catholic social teaching does give greater importance to equality, distributive justice still does not call for equal shares of the world's economic goods.[160] Much of this reflection has evolved through analysis of legal and social justice during the last century.

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[158] For clear outlines of the Catholic natural law approach to economics and the distribution of goods within society see J. J. Piderit, *The Ethical Foundation of Economics*, (Washington, D.C.: Georgetown University Press, 1993); E. Bartell, "Goods, Distribution of" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn.: The Liturgical Press, 1994), 425-432. In his analysis of taxation Charles Curran observed that "distributive justice in the Catholic tradition calls for the goods to be distributed with a heavy emphasis on need. John A. Ryan mentioned five different canons for a just distribution of the products of industry - equality, need, efforts, productivity, and scarcity. Ryan himself proposes a sixth canon, human welfare, which includes all the others but puts a heavy emphasis on need as a basic floor upon which everything else builds." C. E. Curran, "Just Taxation in the Roman Catholic Tradition", *Journal of Religious Ethics* 13:1 (1985): 121-122. The reference is to John A. Ryan (1865-1945) who was the foremost American Catholic social theorist for the first four decades of this century. Much of his work on distributive justice is to be found in his analysis of wage justice. Cf. J. A. Ryan, *Distributive Justice. The Right and Wrong of Our Present Distribution of Wealth*, 3rd. ed., (New York: Macmillan, 1942). For a fuller analysis of Ryan's work see C. E. Curran, *American Catholic Social Ethics: Twentieth-Century Approaches*, (Notre Dame, Ind.: University of Notre Dame Press, 1982), 26-91; within the broader ecumenical scene see H. Beckley, *Passion for Justice. Retrieving the Legacies of Walter Rauschenbusch, John A. Ryan, and Reinhold Niebuhr*, (Louisville, Ky.: Westminster/John Knox Press, 1992), chapters 3 and 5; for a general evaluation see J. M. Burns, "Ryan, John Augustine" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn.: The Liturgical Press, 1994), 851-856.; for critical assessments of his contribution see R. R. Gaillardetz, "John A. Ryan: An Early Revisionist?", *Journal of Religious Ethics* 18:2 (1990): 107-22.

[159] Curran, "Just Taxation...," *Journal of Religious Ethics*, 122

[160] When this consideration is applied to the delivery of health care Philip Keane argues that the distribution question is more significant than the equality one. He sees a number of significant

As noted earlier ancient Greek philosophy frequently employed the term *justice* in a wide or general sense. The just person was the good citizen who advanced the common interest by doing his duty, primarily by obeying the law. For Aquinas, too, justice is the virtue that directs the acts of all the virtues to the common good.[161] The formal object of this virtue is the common welfare and, since law is the chief means by which the common welfare is achieved, it is also called legal justice, the justice which enjoins obedience to the law.[162] Unlike commutative and distributive justice which aim to satisfy the rights of an individual general justice looks to the demands of law and the common welfare. Whereas the former have a limited object in that they grant each one what is strictly due, general justice has a wider scope directing the acts of all the virtues to the common good.[163]

Legal or general justice has important implications in the area of health care. If we agree that an adequate level of health care is a human right, then the citizens are obliged to provide society with the goods that it needs to assure that all have access to adequate health care. This may occur in a number of ways, involving both the private and public sectors. In different historical situations there will be a diversity in the goods that a society requires in order to deliver health care, just as there will be differences in the means used to effect health care delivery.[164] Nothing can be said about "justice in the delivery of health care, unless we conceive of society as having responsibilities to its citizens, and unless we see reasonable access to health care as one of these social responsibilities?"[165]

In Roman Catholic thinking toward the end of the nineteenth century the term *legal* justice was proving to be unsatisfactory since it was widely interpreted at the time as

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problems with the egalitarian notion of justice. "While we are all equal as humans, we do as individuals have different abilities and talents, all of which can work together for the building of the human community. It may well be just for society, acting for the sake of the whole, to give individuals opportunities to develop their differing gifts, even if this means that not every individual is treated in exactly the same way. Similarly, as individuals we can bear different kinds of burdens, especially in an area like health. Some persons with chronic diseases, physical handicaps, developmental disabilities, and other complicated health conditions may very reasonably expect a level of support from the community which other persons should not expect. In addition, there is the whole question of the preferential option for the poor as well as other types of affirmative action programs in which something other than equal treatment seems to be the most just." Keane, *Health Care Reform*, 137-138

[161] "Virtus boni civis est justitia generalis...Justitia legalis dicitur esse virtus generalis, in quantum scilicet ordinat actus omnium virtutum ad bonum commune." (S.T., II-II, 58,6)

[162] Cf. S.T., II-II, 58,5

[163] O'Callaghan, "The Meaning...," in *Moral Theology Renewed*, 164

[164] Keane, *Health Care Reform*, 135-136

[165] Keane, *Health Care Reform*, 139

implying that justice was enshrined in legal codes. The term, therefore, failed to conveyed the idea of a general virtue ordering relationships in society toward the common good. For that reason the term *social justice* came to be adopted in its place.[166] Social justice focuses on institutionalised patterns of mutual action and interdependence that are necessary to effect distributive justice. Within the Roman Catholic ethical tradition, social justice has a meaning somewhat more technical than that in contemporary common usage. It obliges all citizens to assist in creating patterns of social organisation and activity that are deemed essential for protecting minimal human rights and for creating a mutual and participative society. Social justice, in other words, is a political virtue. It is distinguished from other forms of justice because it is based on the human interdependence which occurs within society. Citizens have a personal obligation, mediated through political obligation, to help create a society in which the demands of *agape* can be made effective. This applies to the particular concrete needs of all and to the creation of a reciprocal interdependence within society. Social justice thus emphasises the obligation of the state to promote distributive justice and to make legal claims on all citizens necessary to achieve this end.[167]

It follows from the above outline that commutative, distributive and social justice are interrelated and mutually limiting. All three, in Catholic moral thinking, express the demands of *agape*. All three contain an egalitarian core: equal claims to mutual freedom and fidelity regarding contracts in the case of commutative justice; equal rights to mutual participation in the public good in the case of distributive justice; and equal obligation to assist in the creation of social and political structures which are participative and mutual in the case of social justice. These common elements ground the way preference rules have been developed to reconcile conflicts between the *prima facie* claims of the three types of justice. Precisely because commutative justice cannot be realised in situations of drastic economic or social inequality

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166 Pius XI employed the notion in his encyclical *Quadragesimo anno* (1931) There has been a debate in Catholic circles over the nature of social justice. There are three main opinions: (a) social justice is a new form of legal justice; (b) it is a new form of legal and distributive justice together; (c) it is a new fourth form of proportionate justice at the world level. Cf. Fucek, "Justice" in *Dictionary of Fundamental Theology*, 578. Philip Land has portrayed four dimensions of social justice. First, it is the equivalent of the earlier general or legal justice for its object is the common good. Second, in the name of that common good it commands all specific acts of justice, at a minimum, commutative and distributive justice acts. Third, it is given some central thrust toward organising the institutions of a social and juridical order. It is from this organised and productive society that benefits will be distributed. Fourth, social justice commands individuals, organisations and the state. P. Land, "Justice" in *The New Dictionary of Theology*, edited by J. A. Komonchak, M. Collins, and D. A. Lane, (Dublin: Gill and Macmillan, 1987), 451

167 Hollenbach, "Modern Catholic...," in *Justice, Peace, and Human Rights*, 27

between the partners to a contract or agreement, distributive justice is invoked to set limits to the kind of agreements that can be justly made regarding wages or the lawful gaining of title to property.

The distinction between the types of justice and their grounding in *agape* and mutuality has provided the Catholic moral tradition with a relatively refined language and conceptual framework for discussing complex social problems. It is an approach that provides a degree of objectivity, short of absolute claims, within the relativities of history.[168] In concluding this exposition of Roman Catholic thinking on justice it is helpful to note that during the last one hundred years a major shift has taken place in the normative status that particular social models have had in social analysis. Leo XIII's hierarchical model of society served as a framework for the interpretation of the demands of mutuality and reciprocity. This framework influenced the way justice was viewed and particularly how relative rights and mutual duties were specified. Since the time of Pope John XXIII a reverse direction has been adopted. "The norms of agape - mutuality and concern for the persons in their particularity and uniqueness - are used to evaluate critically both social models and social systems."[169]

8.3.2 Toward a Theology of Justice

Following the Second Vatican Council two discrete phases may be observed in the development of justice teaching in the Catholic Church. The first from 1965 to 1975 focused primarily on the social, economic and political dimensions of justice. Since 1975, as a result of the Medellin Conference of South American Bishops in 1968 and the Synod of Bishops in Rome in 1971, the Church has

> moved more decisively from concern for rational definition to call to commitment to the doing of justice. Connected with this call to commitment is stronger emphasis on love as the form of justice, providing new interior force and motivation. Justice is now being proposed as the first requirement of love. Christian love radicalizes the doing of justice.[170]

The theological dimensions of justice have developed in Catholic theology since 1975 through a consideration of the connections of faith, love and peace with justice. There are aspects of Christian faith that provide special support and a special context for the promotion of justice. The framework of revealed religion places human life within the context of God's providence and redirects priorities to the personal goods

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[168] Hollenbach, "Modern Catholic...," in *Justice, Peace, and Human Rights*, 27-28

[169] Hollenbach, "Modern Catholic...," in *Justice, Peace, and Human Rights*, 27

[170] Land, "Justice" in *The New Dictionary of Theology*, 549

which are essentially interior and spiritual and which are found in response to God's call.[171] This alters the motivations and preferences of persons in the circumstances of justice.

Christian faith interprets the promotion of justice not simply as a temporal political struggle but also as a partial realisation of the fullness of the communion of love given and received in the Kingdom of God. But it also recognises the limitations to which our struggle for justice is subject and places the struggle under the sign of the cross. In every Christian life and in every political struggle to which Christians commit themselves, there comes a moment when the claims of justice must grow silent before the response of faith, of hope, and of love. "Father, into your hands I commit my spirit".[172] In this moment, the claims of justice are not denied or dismissed; nor is the struggle to realise these claims seen as trivial or unnecessary or extrinsic to the life of faith. But in this moment, the Christian recognises that the goal of a just society is not to be attained under present circumstances by the resources now available to us, that the loving union of persons is fully realised only in the Kingdom of God. In acknowledging this moment, Christian faith provides the ultimate basis for a realistic acceptance of the limits of political action for justice as of every other human project and achievement.[173]

Since justice explicates the response that love calls for in the differentiated but connected relationships of social and interpersonal interdependence, it is faith in the paschal mystery of Christ that is central to both Christian action on behalf of justice and to the effort to formulate a Christian definition of justice:

> There is, in short, a Christian theory of justice and an explicitly Christian obligation to seek this justice, both of which are rooted in the covenant love of God for all persons and in the fulfillment of this love in the death and resurrection of Christ.[174]

At first sight justice and charity would appear to be at odds.[175] Justice divides, love unites; justice holds two beings apart in the measure that they are other, charity welds them together so that the other becomes another self. In Christianity the whole quality of justice is altered because the Christian person is a new creature whose purpose in life, the value of activity and the nature of liberty are completely new.

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171 Cf. Is.55:1-2

172 Lk.23:46

173 Cf. J. P. Langan, "What Jerusalem Says to Athens" in *The Faith That Does Justice*, edited by J. C. Haughey, (New York: Paulist Press, 1977), 172-173

174 Hollenbach, "Modern Catholic...," in *Justice, Peace, and Human Rights*, 32

175 W. Werpehowski, "Justice" in *A New Dictionary of Christian Ethics*, edited by J. F. Childress and J. Macquarrie, (London: SCM Press, 1986), 331

Charity is the force which gives other virtues their truly Christian sense and orientation to the last end.[176] Therefore respect for the virtue of justice guarantees the minimum conditions and basis for charity. Its function is to make love possible:

> It is clear, then, that charity does not supersede justice. It carries to ultimate completion the work which it initiates in justice; it does not rest satisfied with the minimum required by right or law; it thinks only of the need of the neighbour. By this very fact it is an important corrective for possible abuses of justice.[177]

Working for the promotion of justice in society is not a matter of defending one's own claims and interests: it entails working for the effective recognition of the justified claims and interests of those who need support in vindicating their rights; it calls persons forth from their own egoism to action on behalf of the needs and rights of others. Presupposed in all of this is motive: either a devotion to a moral or religious value such as justice, or God's will, or an altruistic concern for the plight of other human persons.[178]

The discussion of justice in terms of relative rights and mutual duties is characteristic of the entire modern Catholic tradition. It is based on the conviction that one cannot specify the meaning of *suum cuique* (to each his own) without examining the social relationships, patterns of mutuality, and structures of interdependence that bind human beings together in communities. The normative notion of justice adopted by the modern tradition, which has its historical origins in biblical, Augustinian, and Thomistic thought, is an essentially social concept. It is relational and mutual. Though justice demands respect for human rights on the grounds of individual dignity and worth, these rights are always relative. More precisely, they can be neither specified nor understood apart from the web of social interdependence that entails mutual obligation and duty.[179]

In recent Catholic theological writing peace and justice are joined. *Shalom* is better translated in English as *flourishing*. To experience *shalom* is to flourish in all one's relationships - with God, with one's fellow human beings, with the non-human creation, with oneself.[180] This commitment to human flourishing has taken a

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[176] Cf. S.T., II-II, 23,8

[177] O'Callaghan, "The Meaning...," in *Moral Theology Renewed*, 169. See also G. Gilleman, *The Primacy of Charity in Moral Theology*, (trans.) W.J. Ryan and A. Vachon, (London: Burns & Oates, 1959), 338

[178] Langan, "What Jerusalem...," in *The Faith That Does Justice*, edited by J. C. Haughey, (New York: Paulist Press, 1977), 165

[179] Hollenbach, "Modern Catholic...," in *Justice, Peace, and Human Rights*, 19

[180] Justice was seen by the biblical writers as an indispensable component of flourishing in one's social relationships. Cf. Wolterstorff, "Justice and Peace" in *New Dictionary of Christian Ethics*

particular direction in recent theological reflection and Church *praxis*. A *preferential option for the poor* epitomises a bias in Roman Catholic moral thinking on justice that has great significance for the direction of this thesis in its concern for just health care for aged Australians. [181]

8.3.3 The Preferential Option for the Poor

Due to the influence of the parable of the Good Samaritan the Christian tradition has given a high priority to *works of mercy*. Just as the people of the old covenant experienced a merciful God, so too the Christian community is aware that it is called to express in good works the mercy of God extended to all humanity in Jesus Christ.[182] Works of mercy have traditionally been divided into corporal works (concerned with the needs of the body) and spiritual works (focusing on the needs of the soul).[183] Health care for the aged fits in both these categories. The above consideration of justice has made it abundantly clear that works of mercy must necessarily have a justice dimension. The notion of *preferential option for the poor*, which entered Catholic theology in the years following the Medellin Conference of 1968, provides an appropriate tool for exploring the justice dimensions of works of mercy such as health care for the aged.[184]

A preferential option for the poor does not glorify poverty nor does it canonise the poor:

> it does not imply that the poor are necessarily holier than the well-heeled, that the rich and powerful are by definition evil. It involves a new way of seeing the reality in which we live, seeing it not from the

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and Pastoral Theology, 19-20. For the biblical understanding of justice see J. R. Donahue, "Biblical Perspectives on Justice," in *The Faith That Does Justice*, edited by J. C. Haughey, (New York: Paulist Press, 1977), 68-112; T.L.J. Mafico, "Just, Justice" in *The Anchor Bible Dictionary*, edited by D. N. Freedman, Vol. 3, (New York: Doubleday, 1992), 1127-29.; K. Berger and J. M. Diez-Alegria, "Justice" in *Sacramentum Mundi. An Encyclopedia of Theology*, edited by K. Rahner, Vol. 3, (London: Burns & Oates, 1969), 231-38; from a Protestant perspective see K. Lebacqz, *Justice in an Unjust World*, (Minneapolis: Augsburg, 1987)

181 This term is now enshrined in Catholic social teaching. See John Paul II: *Centesimus annus*, n.11

182 Mt.18:27; Lk.10:37, 16:24; Rom.12:8; Phil.2:1; Col.3:12; Heb.10:34; Jas.3:17; 1 Jn.3:17

183 Among the corporal works are numbered: feeding the hungry, clothing the naked, sheltering the homeless, visiting the sick, ransoming the captive and burying the dead. The spiritual works are instructing the ignorant, counselling the doubtful, admonishing the sinner, bearing wrongs patiently, forgiving offences, comforting the afflicted and praying for the living and the dead. McBrien, *Catholicism*, revised ed., 942

184 Donal Dorr states that the "term 'option for the poor' burst on to the ecclesiastical scene only about twenty years ago. Since then it has become the most controversial religious terms since the Reformers' cry, 'Salvation through faith alone'." Dorr, *Option for the Poor*, 1

> standpoint of the comfortable and powerful, but from the view point of the pressured and powerless.[185]

To make an option for the poor is to commit oneself to resisting the injustice, oppression, exploitation and marginalisation of people that permeate almost every aspect of public life. It is a commitment to transform society into a place where human rights and the dignity of all are respected. This option, or choice, can be made by individuals, by communities or even by a whole Church.[186] At the heart of the option for the poor as it has evolved in the Latin American Christianity are three basic elements. First, there is a commitment by Church leaders not to collude with oppressive regimes but to campaign actively for structural justice in society and to take the risk of throwing the authority of the official Church behind efforts to resist oppression and exploitation. Second, there is a belief that the key agents for bringing about such change must be the poor, the oppressed and the marginalised themselves. This entails a commitment to work *from below*, for and with such groups actively supporting and empowering them. Third, there is a commitment to make the Church itself more just and participative.[187] Structural injustice in society together with the need for personal and communal choices in confronting impediments to human and social development are central factors in the liberation movement.

How people go about achieving social justice is important when speaking about the preferential option for the poor. The first step in the process entails an *experiential* dimension. Here an individual or a group make a deliberate choice to enter to some degree into the world of those who are deprived. They seek to share in a significant way in the experience of being mistreated, bypassed or left helpless. This effort springs from compassion and entails issues of lifestyle. Such an experience of solidarity with the poor provides a matrix within which the virtue of solidarity can be developed.[188] The commitment to do something to redress injustice is the second and political step in the process. This entails (1) careful analysis of the situation, (2) distancing oneself from collusion with the groups or forces responsible for the injustice, (3) carefully planned and concerted action at the political level to challenge

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[185] W. Burghardt, "Characteristics of Social Justice Spirituality", *Origins* 24:9 (1994): 160-161

[186] D. Dorr, "Poor, Preferential Option for" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn.: The Liturgical Press, 1994), 755; for a theological analysis of the option for the poor see J. O'Brien, *Theology and the Option for the Poor*, (Collegeville, Minn.: The Liturgical Press, 1992)

[187] Dorr, *Option for the Poor*, 2

[188] Dorr, "Poor...," in *The New Dictionary of Catholic Social Thought*, 757. The virtue of solidarity "is a habitual attitude and approach that inclines one to be sensitive to the needs and feelings of others in the group and to devote oneself generously to the common welfare"(*ibid.*, 758). John Paul II develops this in *Sollicitudo rei socialis*, nn.38-40

the injustice, and (4) designing alternatives to the unjust structures being challenged and beginning the process to achieve these alternatives.[189]

The liberation of the Hebrews from slavery in Egypt is the paradigm of God's saving work in human history.[190] Once the people had settled in Israel injustice and oppression recurred. No longer inflicted by foreign rulers it was the rich and powerful who oppressed their own people. Through the prophets God protested in outrage against the social injustices, bribery and arrogance of the rich.[191] God demanded that the laws of Israel be upheld to protect the poor, the indebted, widows, resident foreigners, animals and even the earth.[192]

The New Testament built on and enriched the teaching of the Old Testament in regard to the poor.[193] Jesus grew up as one of the common people, his ministry of good news and healing was directed mainly toward them. He presented himself as the one who fulfilled God's promise "to bring good news to the poor, to proclaim liberty to captives."[194] Central to his teaching was the proclamation that the poor and the hungry are blessed by God.[195] Jesus had a particular concern for the rejected and outcasts in his society - the lepers, the sick, the crippled, the disturbed in mind or spirit and those who were classed as public sinners (prostitutes and tax collectors).[196] Especially harsh criticism was levelled at the lawyers and Pharisees who imposed heavy religious burdens on the common people.[197] Instead of endorsing the traditional notion that prosperity is a sign of God's favour Jesus spoke out about the danger of riches.[198]

Critics of the preferential option for the poor way of thinking argue that it violates the norms of *agape* and love of enemies when it depicts the non-poor as class enemies who must be overcome rather than loved. Furthermore, the approach defies justice and common sense by insisting on an overly heroic ethic which requires too much of ordinary lay Christians. Furthermore, preferential option thinking violates

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189 Dorr, "Poor...," in *The New Dictionary of Catholic Social Thought*, 758

190 Ex.3:9; 8:1

191 Am.2:6; 4:1; 5:12; Is.3:14-15; 10:1-2; Jer.22:3

192 Lev.19:33; 25:10-16; Ex.15:12-15; 22:21; 23:11; Dt.23:12; 25:4

193 Cf. T.D. Hanks, "Poor, Poverty" in *The Anchor Bible Dictionary*, edited by D.N. Freedman, Vol.5, (New York: Doubleday, 1992), 402-424

194 Lk.4:18-21

195 Lk.6:20-21; cf. in Mt.5:2-3 the focus is on the "poor in spirit"

196 Lk.5:30; 7:38-39

197 Mt.15:1-5, 16; 23:16-24; Mk.2:23-3:6

198 Mt.6:19, 24; 13:22; 19:24; Lk.6:24; 12:20; 16:22-23

justice by requiring that Christians champion the cause of the poor in every case of political conflict regardless of the concrete facts of the matter. Opponents also offer a number of explicitly theological objections: that (1) it falsely assumes that material poverty is a privileged source of religious truth; (2) it erroneously implies that God does not call the poor to conversion and repentance, and (3) it implicitly rejects the universality of Christ's saving death and resurrection by restricting the mission of the Church to the poor. The common suspicion underlying all these criticisms is that the preferential option advocates an unjustifiable partiality or bias in favour of the poor.[199] In Anglo-American analytical philosophy impartiality has been prized as a trait implying fairness, freedom from bias and resistance to unjust favouritism. For these reasons it has an important role for an understanding of justice. Partiality on the other hand is normally taken to signify undue preference or unjust favouritism, such as promoting one person over another on the basis of family ties rather than other relevant qualifications.[200]

Three criticisms of a preferential option for the poor merit analysis. Preferential option thinking would appear to be guilty of unjustified partiality (1) at the cognitive level by reason of the *hermeneutic privilege of the poor*, (2) in the moral arena when it is affirmed that the poor are the *privileged* objects of neighbour love. They are accused of (3) religious partiality when they claim that God loves the poor *more than* others.

An *a priori* bias in favour of the poor appears justified. The *hermeneutic privilege*, in fact, functions in both descriptive and normative ways. First, the primacy of *praxis* in liberation theology suggests that concrete commitment to solidarity with the poor places one in a social setting more conducive to understanding the suffering of the poor. Second, the *hermeneutic privilege* underscores the need for commitment, action and active engagement in redressing the injustices of society. Technically the poor are no more qualified than others to address the complex issues associated with the structures of injustice. Reading the biblical texts and applying them is not a privileged arena reserved solely to the poor. What is claimed regarding the preferential option is that "certain major biblical themes, particularly divine partiality for the poor, can be more profoundly felt by those who are truly materially poor (that

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199 S. J. Pope, "Proper and Improper Partiality and the Preferential Option for the Poor", *Theological Studies*, 54 (1993): 243-244. Pope's article has been used as the basis of what follows.

200 Note has already be taken of the inability of much post-Enlightenment philosophy to deal with relationships within families and between friends. Affective, emotional and imaginative dimensions of moral decision-making have been a difficulty for analytic thinking. The question of the preferential option, it will be argued, confronts this gap in ethical analysis.

is, if they choose to avail themselves of God's grace)."[201] This is not a class-based epistemological superiority. Rather, poverty provides a special context for discovering and giving witness to God's love and providence. It is not the only area. Far from being biased, "this understanding of the hermeneutic privilege works *against* bias by insisting that we submit to the truth as disclosed in the experience of people who have been hitherto ignored."[202]

Moral impartiality has an important role in the Scriptures.[203] Aquinas himself argued that when pronouncing sentence a judge must not be biased either against or in favour of the poor.[204] As a principle of distributive justice moral impartiality insists on the allocation of benefits and burdens according to relevant and morally defensible criteria. On this account preferential option appears to be a form of reverse discrimination and hence immoral. However as a principle of distributive justice:

> the preferential option rests upon the belief that moral concern should be proportioned to need, where 'need' can be interpreted to include poverty, but also vulnerability, powerlessness, marginality, etc. Other things being equal, Christians should assign priority to addressing the needs of the poor and otherwise powerless rather than to the needs of others because the former are by definition less capable of providing for themselves than are the latter. As a principle of justice rather than simple charity, this preference is not only morally justifiable, it is morally required. Most important, empowerment of the powerless is pursued so that all 'parts' are able to participate properly in the life of the whole community. Inclusivity is diametrically opposed to false, excluding partiality.[205]

Divine partiality of one form is a defining feature of the covenant on Sinai.[206] However with Paul we find that God is no respecter of persons.[207] This underscored his belief that no one will be accorded special privilege or preferential treatment in the final judgment simply because he or she happens to be a descendent of Abraham.[208] To say that God loves the poor "because they are poor" is true at least in a very general sense. It is somewhat misleading, however, since it ignores the fact that God acts in a partial way toward the poor because of the degree of their need.

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201 Pope, "Proper...," *Theological Studies*, 248

202 Pope, "Proper...," *Theological Studies*, 250

203 E.g. Dt.16:18-20; Wis.6:7-8; Dt.10:17-18

204 S.T., II-II, 63,4, ad.3

205 Pope, "Proper...," *Theological Studies*, 252

206 Ex.19:5; Mal.3:1

207 Rom.2:11

208 The author explores these contradictory issues in some detail. See Pope, "Proper...," *Theological Studies*, 253-258

The distinction between *love* and *care* is critical here.[209] Rather than constituting an alternative to love, care is the form love takes when the lover is attentive to the loved one's need. "Because care is proportioned to need, it makes perfect sense to speak of the 'preferential love' for the poor as long as 'love' is specifically understood under its subcategory of 'care' or 'caring love'."[210]

Explanations of the claim that God loves the poor must, therefore, be understood in two ways. First, God's love takes the form of care, mercy and compassion all of which focus on God's concern for the poor in virtue of their suffering. This form of love is completely independent of the virtue, merit or moral attainments of the poor.[211] Second, God's love for the poor looks to the *anawim*, the *poor ones* who have responded to material poverty and physical suffering not with bitterness and hatred toward God but rather with a radical sense of openness to, dependence on and gratitude for God's gifts. Most of all, they are able to recognise the kingdom of God where many others simply do not. It is, therefore, possible to accept that God has a special love for the poor in the sense that God's mercy is proportionate to the degree of need in the poor. It does not imply that God loves the poor *more than* members of other classes nor that he wills them a greater union with himself.

In light of this it is possible to conclude that partiality is justifiable when it contributes to inclusiveness. Inclusivity applies to cognitive and affective comprehension, to recognition of the dignity of every human being, and to an acknowledgement of the comprehensive nature of God's love and the solicitude for the needy that flows from such love. In all three spheres, cognitive, moral, and religious, the partiality of the preferential option appeals to an *expansion* rather than a *contraction* of love and wisdom. Using parts-whole language it can be seen that:

> the preferential option works for an extension rather than a restriction of the interrelationships of parts to one another and of parts to the whole. It is oriented to the proper and full participation of all parts within the whole rather than to the substitution of one system of dominance for another. For this reason its advocates insist that the unity of the Church is only real when it includes the faith, the experiences, and the voices of the poor. Unjustifiable partiality furthers the dominance of one part over

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[209] Pope explores this in the writings of Aquinas ("Proper...," *Theological Studies*, 262-264). In the *Summa* Thomas uses care as that involving a response to need; "the solicitude and responsibility of care is carefully distinguished from the 'connaturality' or 'complacency' of *amor* (1-2.26.2)" (*ibid.*, 262)

[210] Pope, "Proper...," *Theological Studies*, 258. For this reason, Pope continues, "the phrase 'special care for the needy' seems in some ways more specific and more accurate (if less inspiring) than 'preferential option for the poor', 'preferential love for the poor', or 'love of predeliction for the poor'." (*ibid.*, 258)

[211] This is exemplified in the example of the Good Samaritan.

> others and, indeed, over the whole; justifiable partiality, on the contrary, strives to create opportunities for deprived and oppressed parts so that all parts will be able someday to participate fully in the whole.[212]

Inclusiveness, therefore, operates at each of the three levels considered above. In the first place, preferential option advances epistemological inclusiveness by attending to *all* the relevant evidence, including the experience of the poor, and by promoting less ideological descriptions of current social arrangements. The hermeneutic privilege of the poor advances cognitive inclusiveness by insisting on the intellectual and imaginative conversion of the non-poor as well as the poor.[213] Second, the preferential option advances moral inclusiveness by insisting on full participation of all people within the political, social and economic life of local communities. The partiality of the preferential option is proportionate to need rather than merit. Finally, the option advances religious inclusiveness by affirming both God's preferential care and his universal love:

> Proper religious partiality is one of care . . . The poor are the primary focus because of their degree of need, but there is no suggestion that the powerful and affluent properly understand that 'God is love.' On the contrary, only by loving 'nonpersons' can Christians of any social state begin to understand the true universality and depth of God's love.[214]

I believe that an appreciation of the notion, *preferential-option-for-the-poor*, provides a rationale congruent with the theological understanding of justice elaborated. The preferential option criterion has considerable practical importance in analysing the provision of just health care for the elderly. It is to this that our study now turns by examining the issue of just health care delivery from the perspective of Roman Catholic moral theology.

8.3.4 Just Health Care Delivery

In chapter 6 it was noted that, prior to the 1960s, Roman Catholic medical ethics was one of the few disciplines considering bioethical issues. As it had evolved up until that time Catholic medical ethics had focused on clinical issues, applying a set of general moral theological principles to cases primarily concerning medical doctors. The wider issues of health care allocation or rationing, access to health care and the types of health care system received little or no consideration in the literature.[215] There is still a dearth of material considering these issues in Roman Catholic

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212 Pope, "Proper...," *Theological Studies*, 265

213 This is shown particularly in the language of *conscientisation* and *solidarity*.

214 Pope, "Proper...," *Theological Studies*, 266-267

215 D. F. Kelly, "Allocating Health Care Resources" in *Critical Care Ethics. Treatment Decisions in American Hospitals*, (Kansas City, Mo.: Sheed & Ward, 1991), 138

theology. In the English speaking world the U.S. health care crisis is beginning to generate some responses to wider policy issues. Philip Keane has considered that "the reform of our [i.e. the U.S.] health care delivery system is the single most difficult question which we face today in the field of health care."[216] Unlike the situation which pertains in analyses of clinical cases, an adequate framework for addressing health care reform as a social moral issue seems to be lacking in Roman Catholic thinking. Such a framework can be developed on the basis of an understanding of distributive and social justice similar to that outlined in this chapter.

Justice in health care delivery calls for consideration of (1) the type of health care system in place, such as Australia's two-tiered system, (2) questions of access to health care and (3) analysis of allocation or rationing of the health care resources available. A brief outline of the Australian health care scene has already been provided in Chapter 1 as part of the description of aged care services. Philosophical questions surrounding access have been explored in Part II of the thesis.[217] It suffices here to turn attention to the way rationing and allocation have been discussed in Roman Catholic literature on health care.

When developing a set of criteria for just health care delivery in the context of U.S. health care reform Philip Keane adopted the "similar treatment/minimum standard" criteria proposed by Gene Outka in his well known article on social justice.[218] Keane judged this to be close to traditional Catholic thinking provided it is complemented by (1) an acceptance of limits, such as the freedom not to use every life-extending therapy available and (2) a preferential option for the poor.[219] The Australian bioethicist, Liz Hepburn, has argued that discussions on resource allocation fall into two categories, one based on the need for public policy to be just, the other on the principle that public policy must seek to maximise the common good.[220] Throughout,

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216 Keane, *Health Care Reform*, 5. Bracketed explanation is mine.

217 Richard McCormick notes that access problems in U.S. health care are intensified by two characteristics of American health care, viz., widespread commitment to and use of expensive high technology medicine and the preeminence of acute care medicine. Cf. McCormick, *Health and Medicine in the Catholic Tradition*, 75-76

218 Cf. Outka, "Social Justice...," *Journal of Religious Ethics*, 11-32 discussed earlier in chapter 3.2.5

219 Keane, *Health Care Reform*, 143. It would seem that Keane is taking a weaker position on the implications of the preferential option for the poor when he states it "involves a requirement that we take the necessary procedural steps to be sure the poor, cultural minorities, etc., are fully aware that they have access to just health care as a matter of right. However, the actual level of health care services to be made available to the poor need not be different from what we provide to everyone else."(*ibid.*, 143)

220 E. Hepburn, *Of Life and Death. An Australian Guide to Catholic Bioethics*, (North Blackburn, Vic.: Dove, 1996), 172

however, just distribution of health care is never merely a technical exercise. From a Catholic point of view it is always a social and moral issue.[221]

Before considering efforts by Roman Catholic moralists to articulate health care allocation criteria, it is worth noting here that an acceptance of allocation or rationing has been part of the Catholic tradition in the realm of clinical ethics. David Kelly has written of an emerging consensus:

> based first on a recognition that not all treatments which prolong biological life are truly beneficial to the patient (in Catholic ethics this is the distinction between morally ordinary, mandatory treatment and morally extraordinary, optional treatment); second on the general agreement that there is a moral difference between killing (euthanasia) and allowing to die; and third on the legal concepts of autonomy, privacy, and liberty to refuse unwanted treatment.[222]

The most detailed Catholic effort to develop a set of distributive criteria in regard to health care delivery was published in 1991 by the Catholic Health Association of the United States.[223] *With Justice for All?* addresses the definitional problem first of all. The text defines rationing as "the withholding of potentially beneficial healthcare services because policies and practices establish limits on the resources available for healthcare."[224] A number of forms of rationing are judged to be operative in U.S. health care. Rationing occurs in a variety of ways: directly or indirectly; through exclusion policies or establishing program barriers; through inadequate insurance, by *redlining* which excludes individuals from insurance by pricing policies or on grounds of preexisting conditions; by *segmentation* which entails moving away from community rating to experience rating and the segmenting of risk; unequal access.[225]

A number of ethical questions have arisen in Catholic reflection as a result of the denial of potentially beneficial health care. First, there is the general moral obligation

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221 Cf. John Paul II, "Health Care: Ministry in Transition", *Origins* 17:17 (1987): 291-94.

222 Kelly, "Allocating...," in *Critical Care Ethics*, 142

223 *With Justice for All? The Ethics of Health Care Rationing*, (St. Louis, Mo.: The Catholic Health Association of the United States, 1991). This material was presented before the U.S. Senate Special Committee on Aging. Cf. C. J. Dougherty, "Ethical Problems in Healthcare Rationing", *Health Progress* (1991): 32-39. Philip Keane basically follows the same criteria but has included issues such as medical futility, burdensome quality of life and optional treatments as further factors relating to rationing programs. Keane, *Health Care Reform*, 144-148

224 *With Justice for All?*, 6. In reference to the terminology *allocation* and *rationing* Kelly notes that some authors distinguish the terms. "Allocation means deciding on the basis of disease or other medical criteria; rationing means deciding which person or persons of equal need get a limited resource, or deciding on the basis of age or other criteria not considered to be strictly medical. Though the distinction is helpful, I am not persuaded that the two can be completely distinct, or that, as some argue, we ought to allocate but never ration." Kelly, "Allocating...," in *Critical Care Ethics*, 155, note 1

225 *With Justice for All?*, 7-9

to come to the aid of those in need. Second, withholding services may significantly harm individuals. Third, the dignity of persons may be jeopardised when they are denied health care. Fourth, withholding potentially beneficial services may be unfair. In light of these factors the U.S. Catholic Health Association has proposed the following eight ethical criteria for evaluating health care allocation or rationing:

1. The need for healthcare rationing must be demonstrable.

2. Healthcare rationing must be oriented to the common good.

3. A basic level of healthcare must be available to all.

4. Rationing should apply to all.

5. Rationing must result from an open, participatory process.

6. The healthcare of disadvantaged persons has an ethical priority.

7. Rationing must be free of wrongful discrimination.

8. The social and economic effects of healthcare rationing must be monitored.[226]

These eight criteria concisely summarise the theological issues relating to just health care delivery that have been explored thus far in Part III of this thesis. They concretise the wider theological analysis and set the scene for the analysis of the two limits situations that follows in chapter 9.

8.4 SUMMARY AND CONCLUSIONS

8.4.1 Summary

Chapter 8 has outlined in detail the three core notions of *human person*, *common good* and *justice as preferential option for the poor*. Systematic theology has offered a nuanced understanding of the human person in its official social justice teaching and the theologies of the Trinity and creation. Contemporary moral theology has adopted a theologically sensitive personalism that has implications for the process of

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[226] *With Justice for All?*, 19-26. For a somewhat different Christian effort to grapple with the ethical problems associated with resource allocation see J. Wilkinson, *Christian Ethics in Health Care. A Source Book for Christian Doctors, Nurses and Other Health Care Professionals*, (Edinburgh: The Handsel Press, 1988), 375-410

moral discernment. Analysis of the common good provided an insight as to how Roman Catholic moral theory has balanced the communitarian dimensions of human existence with a particular valuation of the human person. Common good as a notion expresses a richer reality than is to be found in ideas such as the public interest. Three emphases dominated the study of justice. First, a wider, personalist and communitarian understanding of justice has reversed a tradition that applied justice thinking in a minimalist, even legalistic fashion. Second, the Christian faith calls for works of justice such that acting justly is integral to the proclamation of the Gospel. Third, justice, the virtue enhancing interpersonal social existence, requires a consideration of all who participate in society. Justice, therefore, is fundamentally inclusive and necessarily preferential in a world where inequalities frequently undermine human dignity. Persons who are deprived of food, work or participation in the political, economic and cultural life of society are to be preferred in the distribution of the benefits of society.

8.4.2 Conclusions

From the study undertaken in chapter 8, I draw the following conclusions:

Regarding the human person:

1. A theology of the human person demands that a wholistic view be taken when thinking about human issues. The person must never be considered apart from his or her social context or environment which are integral to individual human existence. For Christian theology each person is unique and unrepeatable, the gift and icon of God. The human is not an isolated individual but is constituted as human and personal, in the fullest sense, because human existence is essentially interpersonal and intersubjective. Not only is the human person radically relational; as embodied individual the human is also enmeshed in the physical reality of the created universe. Personhood, therefore, demands that attention be paid to individual uniqueness, fundamental intersubjectivity and solidarity with all creation.

2. Human personal existence is radically inclusive. Because humans are interdependent they are responsible for others. A dimension of the moral responsibility that persons experience has been portrayed in this chapter as calling for a preferential option for the poor. This entails a theologically grounded bias and a radical inclusivity that favour those on the fringes of society. Practical

consequences follow when just health care for elderly Australians becomes a matter of public policy.

Regarding the common good

1. Common good thinking demands that attention be given to the social conditions that enhance the dignity of the human person in community and enable each person to participate fully in and for the common good.

2. The freedom, equality and participation of all citizens in society is made possible through respect for human rights. These provide minimum conditions for human life and flourishing in community.

3. Life in community is safeguarded when the principles of solidarity and subsidiarity are respected.

Regarding justice as preferential option for the poor:

Justice is essential to personal and communal existence and necessitates the inclusion of all in society if the common good is to be achieved. In a world of inequalities this may require a preference or priority being given to certain individuals or groups within society. Because of the increasing marginalisation of the elderly, especially the old-old of whom the majority are women, a concern for justice demands preferential care and health care initiatives that facilitate their incorporation into mainstream society.

CHAPTER 9

JUST HEALTH CARE FOR THE AGED: TWO RESOLUTIONS

9.1 Age and Health Care: Deficiency of the Criterion 462

9.2 Christian Responsibility and the Experience of Limits 464

9.2.1 The Christian Virtue of "Pietas" 465
9.2.2 Christian Responsibility and Parents 473

9.3 Summary and Conclusions 476

9.3.1 Summary 476
9.3.2 Conclusions 476

CHAPTER 9

JUST HEALTH CARE FOR THE AGED: TWO RESOLUTIONS

This chapter revisits issues previously discussed from a philosophical viewpoint in chapter 5. The experience of limits in contemporary health care generated controversy on two specific issues. The first concerned the policy proposal that age should be a criterion in deciding on the delivery of health care. The second, more general question, arose in the philosophical literature as a problem of intergenerational obligations. As stipulated earlier, these are the two dimensions of justice that have been chosen as the focus of this thesis. Part III has moved from a background consideration establishing the relevance of Roman Catholic moral theory in chapter 6, through the problematic issues of meaning in chapter 7, to the key ideas elaborated in the last chapter, to arrive at the point where the two specific justice questions that directly concern health care for the elderly may now be considered. The structure of Part III deliberately mirrored that of Part II, moving from the more general to the more specific. Chapter 9 brings the investigations of Part III into sharp focus by offering a theological analysis of the age criterion and the intergenerational obligations question. The chapter thus builds on the extensive investigations of chapters 6-8. The conclusions drawn in the course of chapter 9 clarify the justice dimension of the thesis topic and provide a bridge back to a consideration of health care delivery for elderly Australians that introduced this study.

I argue in this chapter that Roman Catholic moral theory substantially resolves the questions raised by the experience of limits in the delivery of health care to the elderly. Chapter 7 showed that an understanding of aging, well-being and care must be *framed* by a number of basic values. An understanding of human aging is transformed when framed by notions of human life and death. Well-being is a matter both of health and illness and when framed by notions of the human body and the realities of pain and suffering is radically altered. Caring, likewise, when framed by a Christian understanding of *agape*, is profoundly changed at the levels of personal motivation and performance. This framework is a necessary prerequisite for a satisfactory analysis of the justice questions arising from the experience of limits. In light of the theologically rich notions of the human person, the common good and justice as preferential option for the poor, developed in the preceding chapter, it is now possible to argue (1) that the proposal for an age criterion governing health care delivery for the elderly must be rejected. On the basis of the theological

understanding of the human person and justice as preferential option for the poor outlined earlier I hold that the policy is misguided in its understanding of limits and unjust should it ever be implemented. Furthermore, (2) on the basis of the above understanding of the human person and the common good I argue that the obligations in adult child - elderly parent relations are minimal requirements for family and social life, and that the notion of *responsibility* provides a more adequate conceptual tool for understanding intergenerational relations. The bioethical discussion of intergenerational *obligations*, presented in chapter 5, proved to be one-directional as it focused mainly on the duties of children *toward* their parents. The concept of *responsibility*, on the other hand, recognises not only the duties of adult children to their parents but includes the obligations of elderly parents to their children, families and the wider community. For this reason, the notion of responsibility in theological reflection provides a more adequate and satisfactory picture.

9.1 AGE AND HEALTH CARE: DEFICIENCY OF THE CRITERION

In chapter 5 the philosophical discussion of the age criterion was canvassed in some detail. Two factors contributed to the course of the discussion in the U.S.A.: (1) the imperative to ration health care in the context of increasing costs and growing demand; (2) the adversarial quality of relations between the elderly and the young around the question of intergenerational equity.[1] Many authors have rejected age as a criterion for limiting health care delivery.[2] Should it ever be justifiable, rationing health care should be age neutral and access should be restricted to expensive medical interventions and to persons who have little likelihood of benefit. Where the line is drawn regarding these two exclusion categories will vary depending on the resources of a particular society. A reasonably full basic health care package available to all is presupposed in this scenario.[3]

A theologically grounded rejection of Callahan's proposal may be articulated by drawing together a number of threads within the argument developed in the

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1 Post attributes this development to the work of the sociologist S.H. Preston in 1984. Cf. S. G. Post, "Old-Age-Based Rationing, Dementia, and Quality of Life" in *Inquiries in Bioethics*, (Washington, D.C.: Georgetown University Press, 1993), 115

2 See ch.5.1.4 for detailed references

3 Cf. Post, "Old-Age-Based...," in *Inquiries in Bioethics*, 119. He further observes. "In the event that rationing health care ever becomes necessary for either the entire population or a portion thereof, it will of necessity be justified on the basis of the common good."(*ibid.*, 120)

preceding three chapters of this thesis.[4] In chapter 6.1.3 *vision* was seen to have a critical role in the development and functioning of the moral life. An individual's understanding of what it means to be human and to act in a virtuous way is shaped by the vision of the community within which he or she lives. The power of imagination and stories to paint a picture of the world together with the powerful example of good people contribute to shaping the ethos of a community. A moral vision, if it is true, must attend to all the values at stake and must enable an integration of the physical and spiritual dimensions of moral behaviour. The proposal for an age criterion that rations health care, thus excluding a certain group among the elderly, would appear to contradict the vision of the moral life drawn in a theological context.

The vision of *aging* and *well-being* developed in the theological investigation of chapter 7 is of considerable importance for rejecting the age criterion proposal. In Roman Catholic thinking human life is a fundamental value upon which all other values build, including the duty to respect and care for life, to protect and promote human health. The inevitability of aging and death bring with them an understanding that human life is limited. Embodied persons are called to value their physical state throughout the life journey even when that body is a cause of pain and suffering as part of the process of senescence.

Quality of life, in Catholic moral theology, considers the intensity of pain and suffering in an individual's life but places this in the context of the person's self-understanding and life projects. Physical, psychological and spiritual issues are important for the person's well-being as is the unique life-story that gives meaning to who the person is. Furthermore, the communitarian framework of the Christian life, with its emphasis on human solidarity and the duty to care for others after the example of the Good Shepherd, indicates an unwillingness to classify certain persons as beyond the pale once they have reached a designated age. Respect for human dignity, prizing their unique story, recognising interdependence and, above all, acknowledging the duty to care for the neighbour especially in times of vulnerability, suggest that a designated cut-off point in health care delivery would be antithetical to all that Christians hold precious. These priorities apply to the human person without exception from conception to death.

As has been demonstrated in chapter 8.1, a theological conception of the *human person* emphasises the important role of human interdependence arising from the

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[4] David Kelly accepts that although age as a criterion for allocation cannot be ruled out *a priori*, there still remain serious political and ethical obstacles to its practical implementation. Kelly, "Allocating...," in *Critical Care Ethics*, 150-151

poverty of shared creatureliness and the profound mystery of each unique individual. The sacramentality of each person, especially the elderly, has an important role in the life of the community. To ignore both these dimensions of creaturehood once an individual has attained a certain point on the life span negates the two key dimensions of poverty and sacramentality associated wih a theological view of the human person.

At a time when aged persons are being increasingly marginalised in society and the old-old, who in the forseeable future will be predominantly women and poor, are susceptible to greater discrimination, a concern for justice is imperative. The exploration of *justice as preferential option for the poor* in chapter 8.3 has emphasised a view of justice dictated not only by equity but also by inclusiveness. The pressure to exclude from health care services persons beyond a designated age may only be countered in a satisfactory way when health care policy adopts a view of justice that is partial to all aged persons and that seeks to give preference to them because of their need or vulnerability. For this reason an age criterion is unjust.

In light of these considerations it is possible to conclude that the age criterion proposal is misguided in its understanding of limits. Furthermore, it discriminates against aging persons in the community and is unjust since it relegates this group to the status of second class citizens at a time when they should be shown preferential treatment demanded by the claims of justice.

9.2 CHRISTIAN RESPONSIBILITY AND THE EXPERIENCE OF LIMITS

In chapter 5.2 the dilemmas associated with the experience of limitation were portrayed in terms of *intergenerational obligations.* Much of the urgency found in the American debate about intergenerational obligations arose from particular characteristics of the American political, economic and health care scenes. All commentators agree that there are enormous pressures on adult children in fulfilling their obligations towards aging parents. Roman Catholic moral theory contributes to the issue by providing a faith based communitarian framework where all groups in society are challenged to work for the common good and to give preference, as a matter of justice, to the poor, the needy and the vulnerable. The fourth commandment and the teaching of the New Testament call believers to live and act responsibly within the family situation. This obligation necessitates moral discernment in balancing competing claims, places an emphasis to the vocation and obligations of

elderly parents as well, while assuming a framework where social institutions offer effective support when care of elderly parents is beyond the capacities or resources of adult children. The theological discussion throughout Part III provided a frame of reference and a set of basic notions that both Daniels and Callahan had intimated were essential for just health care for aged persons. Daniels had argued for a closed system that permitted his ideal theory of justice to be implemented effectively. In this he looked for a framework that chapter 7 has provided from within a theological tradition. Callahan argued for a social consensus in American society that contributes to a realistic minimalist ethic. The key ideas articulated in chapter 8, I have argued, fulfill this requirement. Before drawing together the threads of the theological analysis provided in Part III to resolve the issue of intergenerational obligations it is important to outline the explicit demands of the Christian tradition regarding the duties and responsibilities of children toward their parents. [5] This substantive teaching has traditionally been considered under the virtue of *piety* or *pietas*.

9.2.1 The Christian Virtue of "Pietas"

Pietas is the virtue expressing honour to one's parents together with the duty to obey and serve them.[6] We have already observed that Anglo-American philosophy has been sceptical about the duties children owe to parents. A number of explanations have been offered. Some argue that the obligations children have to their parents are imposed, not chosen; hence there is no duty incumbent on them. Others are disinclined to recognise a moral basis for involuntary self-sacrifice or see such duties as merely sentiments of filial responsibility, a non-rational emotional residue of childhood. Still others consider that the duties of adult children ought to be proportioned to the degree of friendship they have with their parents. Norman Daniels has portrayed the intergenerational obligation to care for the aged as a call for the impersonal distribution of goods and services. This, he argued, requires the deliberate specification of standards of justice between generations.[7] In sociology proponents of the *critical school* have rejected the various forms of philosophical

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[5] Intergenerational obligations may be considered from three points of view: obligations of (1) child/children to parents, (2) the young to the old, (3) the present generation to future generations. In this thesis the first two are of primary concern. For some of the implications of the third dimension see Norton, "Future Generations…, " in *Encyclopedia of Bioethics*, 892-99

[6] Cf. T.O. Martin, "Piety, Familial" in *New Catholic Encyclopedia*, Vol.11, (New York: McGraw-Hill, 1967), 356-358; for a philosophical analysis of the notion *pietas* see D. Walhout, "Piety, Value, and Culture" in *The Good and the Realm of Values*, (Notre Dame, Ind.: University of Notre Dame Press, 1978), 21-38

[7] Cf. D. Christiansen, "Intergenerational Relations" in *Duties to Others*, edited by C. S. Campbell and B. A. Lustig, (Dordrecht: Kluwer Academic Publishers, 1994), 249

coolness regarding child-parent duties. The individualism and contractualism so evident in Anglo-American moral philosophy

> is part and parcel of the rationalism characteristic of the two principal social entities of the modern period, namely, the market and the state. The intimate sphere of informal relations constituted by the family, neighborhood, church and community is caught between the self-interested moral code of the market economy, on the one side, and the calculated benevolence of the state on the other. The result is a serious loss of the moral habits which permit sustained sacrifice for the sake of others, including children and the elderly.[8]

In chapter 5.2 it was argued that the prevailing emphasis on autonomous self-sufficiency fails to include the social costs accompanying this stand. In fact attending to both the elderly *and* their families addresses the issues of intergenerational justice.[9]

Catholic social teaching has affirmed the right of all persons to social security and health care services in old age.[10] While affirming the basic nature of this right to care and support no concrete implementation options are preferrred in official Church teaching. Care-centred public policy may, I suggest, better serve the needs of the frail elderly in particular and may, in fact, offer more useful assistance to care-givers than present cure-centred policies. The communitarian focus of Catholic teaching has repeatedly emphasised the state's obligation to provide the aged with what is necessary for basic human existence, thus rejecting any legal enforcement of filial responsibility.[11] This stance assumes a context of responsibility that emphasises the moral obligation on each child to care for his or her parents:

> This general moral obligation is grounded in the very nature of the parent-child relationship and in what the parent has previously done for the child. The primary general responsibility is one of care, concern, and personal relationships.[12]

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8 Christiansen, "Intergenerational...," in *Duties to Others*, 249

9 Cf. E. Kingston, B. Hirshorn and J. Cornman, *Ties That Bind. The Interdependence of Generations*, (Washington, D.C.: Seven Locks Press, 1986), 51-68

10 Cf. D. Christiansen, "Aged, Care of" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn.: The Liturgical Press, 1994), 19

11 C. E. Curran, "Filial Responsibility for an Elderly Parent", *Social Thought* 11:2 (1985): 46-48. The author commences his study with the Elizabethan Poor Laws and elaborates eight reasons for his position.

12 Curran, "Filial...," *Social Thought*, 49. Christiansen observes in relation to the U.S. that where the elderly enjoy entitlements, as in the U.S., that result in social imbalance, such advantaged groups ought to sacrifice their entitlements for the sake of the common good when continued enjoyment of those rights would make them a privileged group at the expense of other groups. Christiansen, "Intergenerational...," in *Duties to Others*, 255

The basis of this teaching in the Judaeo-Christian tradition is to be found in the ten commandments, or decalogue, which articulate the core requirements for life in the covenant community. The fourth commandment: "Honour your father and your mother so that you may have a long life in the land that Yahweh your God has given you" is central to Jewish and Christian teaching on duties to parents."[13] The Law of Holiness, in the book of Leviticus, states that "each of you must respect his father and mother."[14] Jewish catechetical tradition frequently used the precepts of the Holiness Code as a source of instruction on the Law.[15] In his classical treatise on the 613 commandments of the Torah, the great Jewish philosopher Moses Maimonides cited the commandment demanding piety as the 210th and 211th. precepts of the Law.[16] More recent Jewish scholarship has distinguished *morah* or reverence from *kibbud* or honour.[17] It is this latter notion which is contained in the fourth commandment. The Jewish notion of honour indicates that which is heavy and weighty. To honour a person is to acknowledge him or her as a person of importance and of worth. It is a response to the weightiness of the person honoured. For this reason rabbinic scholarship did not consider the fourth commandment as primarily obliging children. Rather the honour to be given to parents appears to be not so much a pattern of youth as it is the pattern of a lifetime.

Within the Jewish tradition four reasons were offered as to why one must honour one's parents. First, parents are creators. The honour bestowed on parents is a continuation of the honour rendered to God. Second, there is the element of gratitude. Philo, an Alexandrian Jew and a contemporary of Jesus, located filial gratitude in the

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13 Ex.20:12. Note that this commandment is designated as number five in the Hebrew and Protestant traditions and as the fourth in the Catholic tradition. The latter designation will be followed here. The inclusion of a promise with the commandment points to the earliest origins of the commandment as a stand against the practice of primitive communities which abandoned the elderly once they were non-productive. As Collins comments "the promise of a long life is consistent with the command to honor your father and mother insofar as those who fulfill the commandment effectively procure a (relatively) long life for their parents." R. F. Collins, "The Fourth Commandment - For Children or for Adults?" in *Christian Morality: Biblical Foundations*, (Notre Dame, Ind.: University of Notre Dame Press, 1986), 89

14 Lv.19:3a

15 Lv.17-26

16 Collins notes that the rabbinical tradition distinguished 613 commandments of the Law. The 613 commandments included 365 proscriptions and 248 prescriptions. "According to the Talmud, Rabbi Simlai is reputed to have stated that, '613 commandments were revealed to Moses at Sinai, 365 being prohibitions equal in number to the solar days, and 248 being mandates corresponding in number to the limbs of the human body.'...A modern reader might find the enumeration forced but he cannot argue with the basic insight - that evil is to be avoided all the days of a man's life; and good is to be done with the whole of his being." Collins, "The Fourth Commandment...," in *Christian Morality*, 95, note 1

17 G. Blidstein, *Honor Thy Father and Mother. Filial Responsibility in Jewish Law and Ethics*, (New York: KTAV Publishing, 1975), 39, 47

gratitude owed to benefactors. Third, proper observance of the commandment contributed to the stability of society and fourth, it ensured the preservation of the religious traditions.[18]

The nature of filial responsibility is developed in a number of pentateuchal verses: "Anyone who strikes his father or mother must die."[19] "Anyone who curses father or mother must die."[20] "A curse on him who treats his father or mother dishonourably."[21] In a pithy maxim the Jewish Talmud illustrates *reverence*: "Reverence means that *the son must neither stand nor sit in his [father's] place, nor contradict his words, nor tip the scale against him.*" The principle behind this pattern is clear: nothing is to be done that might diminish the dignity, and hence the feeling of worth, of one's parent - either father or mother.

> Reverence (*morah*) is expressed in this unegalitarian reserve, which demonstrates behaviorally the qualitative gulf in status separating parent and child. Indeed, parental dignity is here virtually identical with inviolability and superiority, just as respect shown others generally expresses itself in self-abnegation of some sort.[22]

When honouring a parent the child undertakes personal service.[23] This entails food, drink, shelter and care. Obviously this is demanded of adult children who have the material resources to assist their parents. It is discussed in rabbinic casuistry in terms of the obedience which children owe their parents. These discussions "show that obedience is generally not to be dissociated from honor rendered in the form of personal service."[24]

Two texts are of particular interest in that they convey the understanding of the fourth commandment in the Jewish community of Jesus' day. In his meeting with the

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18 Blidstein, *Honor Thy Father and Mother*, 1-36

19 Ex.21:15

20 Ex.21:17

21 Dt.27:16. In his commentary on these three texts Harrelson observes: "The first, 21:15, provides the death penalty for anyone who strikes father or mother. The action in view is certainly that of a young and truculent teenage son who will no longer yield obedience to parents - such action is specified all the more clearly in Deut.21:18-21. The second of these passages has something beyond the use of abusive language in view. To curse one's father or mother means to treat them as of no consequence or value, to wish them removed from the scene, to desire their obliteration. And that suggests that the parents are aged or frail and have become a nuisance to the active adults who would very much like to be relieved of further responsibility for such aged ones." W. Harrelson, *The Ten Commandments and Human Rights*, (Philadelphia: Fortress, 1980), 94

22 Blidstein, *Honor Thy Father and Mother*, 39

23 Cf. Sir.3:1-16; Blidstein, *Honor Thy Father and Mother*, 47

24 Collins, "The Fourth Commandment...," in *Christian Morality*, 87. Hebrew casuistry explored the limits of this obligation in situations of confict. For a survey of the relevant literature see Blidstein, *Honor Thy Father and Mother*, 80-121

rich young man Jesus enumerates the commandments.[25] The young man responds that he has kept them from his youth. The response is not that of an arrogant opponent of Jesus but rather expresses the blamelessness of a faithful Jew before the Law.[26] Another text in the gospel of Mark which sheds light on the early Church's understanding of the commandment is to be found in the *corban* pericope.[27] Jesus criticised his opponents who used a traditional practice, a vow about which there is exegetical debate, to avoid the demand of the Law. The text addresses the person who fails to support his parents because the goods which ought to have been used for their support were, in some way, dedicated to God. The pericope does not focus on the child's obedience, rather it concentrates on the care and economic support that should be given to aging parents.

In the letters of the New Testament one finds a collection of admonitions whose literary genre is that of *rules for the household*.[28] These collections address the obligations of different members of the Christian household. Their inclusion served a theological and an ethical purpose. Theologically, the author of the letter intended to affirm the lordship of Jesus over all human relationships. Ethically, he intended to strengthen family ties within the Christian community. From Hellenism, with its household codes, came an emphasis on the obedience of children toward their parents. From Judaism and the rabbinical tradition came the citation of the fourth commandment.[29]

In ancient and medieval culture the injunction of the fourth commandment to honour one's parents was reinforced by the value Roman society placed on the virtue of *pietas* as devotion to family and country.[30] While the patristic literature elaborated this obligation it is Aquinas who summarised the tradition when he wrote "just as it is proper to religion to show devotion to God, so at a second level it is proper to show devotion to parents and country."[31] For Aquinas piety is viewed as a higher form of gratitude. Gratitude does not obligate us to respond to all our benefactors in the same manner, with the same degree of devotion. On the contrary, "the nature of

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[25] Mk.10:17-22; cf. Mt.19:16-22; Lk.18:18-23

[26] Collins, "The Fourth Commandment...," in *Christian Morality*, 91

[27] Mk.7:9-13

[28] Exegetical literature applies the German term *Haustafeln* to a literary genre originating in the Hellenistic world. Cf. Eph.5:22-6:9; Col.3:18-4:1; 1 Tim.2:8-15; 5:3-8; 6:1-2; Tit.2:2-10; 1 Pt.2:13-3:7

[29] Cf. Collins, "The Fourth Commandment...," in *Christian Morality*, 92-93

[30] Aquinas described *pietas*: "Hoc autem principium respicit pietas, inquantum parentibus et patriae, et his qui ad haec ordinantur, officium et cultum impendit." (S.T., II-II, 101,3)

[31] S.T., II-II, 101,1

the case requires that a recipient respond to his benefactor in a way that reflects their relationship".[32] Since our relationship with our parents is so closely bound up with who and what we are, more is required of children to demonstrate their gratitude and appreciation of them than to any other benefactor, with the exception of God. Just what is required of children cannot be determined with the precision that would be possible if filial obligation were a matter of justice, for gratitude looks to the nature of the particular family and of the particular relationships within it, and not, as in the case of justice, to an "equality . . . of external objects."[33] Aquinas, therefore, understood filial piety as based in the natural order, that children owe certain duties of honour, respect and care for their parents. This view is grounded in gratitude for the giving of existence by parents. For the natural law tradition, then, this gratitude is the basis of filial piety.[34]

In recent times, as the population ages, increasing burdens are being placed on families through the care of elderly parents and relatives. In the U.S.A. in particular two characteristics have become obvious in the dynamics of families with elderly members. First is *counter-dependency* which refers to the exaggerated fear of dependency, particularly the normal dependencies of the human life-cycle. Counter-dependency is a cultural trait, with people in the U.S.A. expressing more aversion to dependency than those in most other countries. The second phenomenon is *intimacy-at-a-distance*. This is a pattern of familial relations in old age which helps both generations maintain their independence for an extended period by the maintenance of two separate households through cross-household helping arrangements, regular visiting, and frequent phone contacts.[35] Both these phenomena are present, although perhaps to a lesser degree, in Australia. At the same time there is considerable resistance to the premature institutionalisation of elderly family members, a step often viewed as a "last resort".

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[32] S.T., II-II, 106,3

[33] S.T., II-II, 106,6. Cf. J. Blustein, *Parents and Children: The Ethics of the Family*, (New York: Oxford University Press, 1982), 61-62

[34] For current official Catholic teaching on the obligations of the fourth commandment see *Catechism of the Catholic Church*, nn.2197-2246. Cf. Brakman, "A Philosophical Analysis...," Ph.D. Thesis, 100

[35] Christiansen, "Intergenerational...," in *Duties to Others*, 251. The remainder of this section is heavily dependent on the work of Drew Christiansen, a Jesuit ethicist, who has had a continuing interest in aging issues since completing his doctoral dissertation at Yale University on problems of dependency in old age. He has contributed to the article on aging in the 1978 edition of the *Encyclopedia of Bioethics* and in a number of journal articles. He works in the area of social ethics at the U.S. Catholic Conference in Washington.

Fulfilling filial obligations entails a number of significant tasks: support, care and respect. Support entails financial assistance which preserves the elderly person from hardship and poverty. In addition services must be provided when the impairments of age prevent individuals from doing things themselves, such as shopping, caring for the family home and coping with bureaucracies. Care refers to the more intimate work of bathing, grooming and nursing the enfeebled or chronically ill old person. Care is associated with basic nursing tasks including the supervision of medication and assisting with basic therapies. Respect calls for deeds that contribute to the old person's well-being and self-respect. These include visiting, gift giving and other expressions of esteem and affection. These activities "contribute to reverence for elders in that such services preserve them from neglect and establish a ring of privacy that shelters enfeebled and senile persons from the public derision that attends isolated living (or abandonment)."[36]

In a Christian context a special form of respect for old persons may be found in the spiritual friendship between them and their caregivers or between the elderly and adult children. Housebound or bed-ridden aged persons have often outlived many of their contemporaries and frequently desire companionship more than physical care. A number of life tasks confront the frail elderly. Among these is the need to integrate their life experiences, coping with disengagement and loss, awareness of finitude, diminishment and death. By listening to their stories, sharing their feelings and praying with them, family members and other caregivers can assist frail and sick old people in meeting these psychological and spiritual needs thus enriching their final years within the family network. These tasks are often quite difficult for family members and caregivers to fulfill because of the combined pressures of care and their own family commitments.[37]

A moral rationale for family care-giving can be given.[38] It lies in the complex network of values that constitute human dignity. In the family setting, old people find

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36 Christiansen, "Aged...," in *The New Dictionary of Catholic Social Thought*, 17

37 D. Christiansen, "Creative Social Responses to Aging. Public Policy Options for Family Caregiving" in *Concilium*, edited by L. S. Cahill and D. Mieth, (London: SCM Press, 1991), 117, 119-121. This problem is replicated in aged care accommodation where funding restrictions causing reduced nursing hours and greater use of casual staff have created discontinuities in the care of the elderly.

38 This rationale must be judged against a long and ambivalent history of reticence regarding the role of the family in the Christian life. Margaret Farley indicates that three strands are to be found in Christian attitudes to the family: (1) *rejection*: all family bonds and responsibilities have been relativised in favour of an imminent realm of God in which unity with God and all persons would transcend the special human relations that were in place before its coming. Cf. Mt.10:34-39; Lk.12:51-53. (2) *substitution*: the Christian community offers a kind of membership, of belonging, that abolishes all barriers of nation and gender and economic status (Gal.3:28). While

physical support and care, social interaction and a wider margin of freedom than anywhere else.[39] Contrary to philosophical preoccupations with personal autonomy and the fear of paternalism, filial responsibility may be viewed theologically as responding to risks to the *dignity* of the elderly. This is required particularly in times of chronic ill health and impairment. Filial responsibility, therefore, is a basic defence of the dignity of the elderly against the vulnerabilities created by failing health and diminished self-reliance in old age.[40] Filial responsibility serves the human dignity of the aged person when reliable care is provided, the greater vulnerability of institutionalisation or paid care is obviated and the experience of more personal and responsive social relations is present.[41]

U.S. public policy, with its bias toward helping only needy individuals, has been reluctant to acknowledge the significant contribution of family members to the care of the elderly.[42] The same can be said of the Australian scene:

> Familial justice can offer only broad guidelines for sharing the duties of eldercare. The daily demands and extended sacrifices of caregiving cannot be measured out exactly. Justice can re-apportion some of the burden among family members, but caregiving will always demand a degree of sacrifice which can be justified only in an ethics which allows for virtuous relations in the domestic sphere.[43]

A public policy that serves both the elderly and their families would contribute greatly to the attaining of intergenerational justice. Where care is a primary concern many practical steps can be taken to enhance the care of the elderly within the family context, such as the provision of respite and domiciliary care. Because of this there is increasing need for the education of family caregivers assisting them in the service they have undertaken.[44]

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this was a promise for the future, it also could be experienced in the present. (3) *affirmation*: Christians also believed that marriage and the family in the ordinary sense could be affirmed, not abolished in their new life of faith. All three attitudes have been continually in tension for twenty centuries. Because of this she is able to assert that "the family is barely visible in Christian theology and ethics, and insofar as there is a Christian understanding of the family, it has not developed very much over the centuries." M. Farley, "Family" in *The New Dictionary of Catholic Social Thought*, edited by J. A. Dwyer and E. L. Montgomery, (Collegeville, Minn.: The Liturgical Press, 1994), 371

39 Christiansen, D. "Creative...," in *Concilium*, 119

40 Christiansen, "Intergenerational...," in *Duties to Others*, 251-252

41 Christiansen, "Intergenerational...," in *Duties to Others*, 252

42 Christiansen, "Intergenerational...," in *Duties to Others*, 253

43 Christiansen, "Intergenerational...," in *Duties to Others*, 254

44 Christiansen, D. "Creative...," in *Concilium*, 121-122

Contemporary theological reflection, with its emphasis on community, solidarity, personal responsibility for the well-being of others, provides a much *warmer* or humanistic attitude to care of the aged. This stands in stark contrast to the *cool* and problematic rationale offered in the philosophical literature. With the Christian virtue of *pietas* the comprehensive notion of personal moral responsibility comes to the fore. This offers an approach that more adequately addresses just health care for the elderly than is to be found in rational explanations of obligations, rights and contractual frameworks central to the ethical response.

9.2.2 Christian Responsibility and Parents

The philosophical analysis of intergenerational obligations has been shown in chapter 5.2 to be defective on two counts. It fails to explain adequately the grounds for this particular type of obligation and does not satisfactorily describe the scope of the obligation. In light of the richly textured theological understanding of the virtue of piety just outlined I argue, in what follows, that a more satisfactory resolution of the question of intergenerational obligations may be constructed from elements outlined in the theological exposition undertaken in chapters 6 to 8.

In chapter 6 a theological account of freedom was presented from the point of view of human *responsibility*. The strength of this notion lies not only in the fact that it is grounded in a nuanced and comprehensive understanding of human freedom but also because it shifts the focus from what is owed to the complete network of relationships, especially covenant, within which obligation is experienced. Two elements should be highlighted here. First, responsibility points to interpersonal relationships that imply a mutuality of obligation. Second, the network of relationships is comprehensive in its scope involving not only God, but the neighbour, the world and the self as well. Obligations in this account are multi-lateral and interpersonal. The covenants of the Old and New Testaments attest to the profound importance and relational texture of responsibility in the Jueaeo-Christian tradition.

In his effort to explain the scope of intergenerational obligations Daniel Callahan was forced eventually to recognise that many situations of heroic care for others may only be adequately understood within a religious framework. Our consideration of beneficence, philanthropy and altruism in chapter 3 and the philosophical perspective of intergenerational obligations in chapter 5 support Callahan's conclusion. In chapter 7.3 an extended theological reflection on *charity as care* gives context and orientation to the duties owed by adult children to their aging parents. The context

arises from an understanding of *agape* as gift and call. Christians understand themselves to be loved by God in Jesus Christ and called to love "as I have loved you". This places care of one's parents within the framework of the God-focus that Jesus' love calls Christians to live. Care of elderly parents, in the Christian scheme of things, demands attention to personal motivation and performance both of which must be sustained over long periods of time particularly when the aged are frail, disabled or chronically ill. This most challenging form of care demands a commitment and a sense of vocation that at times is almost heroic. At the core of the Christian notion of charity as care is the important place given to interpersonal relations and to the fact that care entails a mutual interchange of equals within a covenantal community.

Roman Catholic moral theory has placed an understanding of the *human person* at the centre of all its moral considerations. This is particularly the case when exploring the obligations of adult children to care for their aging parents. While life exists the dignity of the human person calls for respect. As the tradition of social reflection outlined in chapter 8.1.2.1 has indicated this respect emphasises the participation of all in the social task. The model of the Trinity places the mutuality of unique persons in community to the fore while the doctrine of creation reminds us that all persons are finite creatures and thus dependent on one another. The incarnation and resurrection of Jesus Christ has transformed human creatureliness such that every person is now sacramental. These perspectives on the human person ground the multi-dimensional and inter-relational character of Christian responsibility just considered. The obligations incumbent on adult children regarding the care of their parents also implies that parents, as members of a covenantal community, have obligations to their children, their family and to the wider community of society. The responsibilities of parents have been rarely discussed in the philosophical literature of the liberal society.[45] From a theological point of view the responsibilities of parents to their family and the wider society merit as much detailed analysis as the responsibilities of adult children.

A key to developing the multi-lateral dimension of familial responsibilities, especially emphasising the obligations of parents, is to be found in the notion of the

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[45] It is important to note here the existence of a genuine human concern for which there has been no philosophical expression and no generally acceptable language for expressing it. Preoccupation with the family has remained below the surface of contemporary public life. This is well exemplified in the sacrifices that parents, and especially immigrant parents, have made that their children have a better standard of living. This thesis has argued in reference to aging in Australian society that there exists a richer texture to human living which contemporary philosophy has failed to consider.

common good elaborated in chapter 8.2. Catholic tradition of the common good sees a healthy tension between the individual person and the common good. Both must be respected, enhancing one enriches the other. In this scheme of things no one individual or group is exempted from responsibility for the common good. This has special relevance for parents and raises the question as to what and who they contribute to the common good. In light of the earlier study of human aging there is room to develop a clearer picture of the role of aged parents both within their own families and within the wider community. The approach to the common good discussed in this thesis implies a particular political and social theory. In this view recognition of human interdependence leads to the virtue of solidarity. Complementing this has been the traditional use of the notion of subsidiarity. Solidarity points to social cohesiveness, epitomised in family relationships. Subsidiarity makes clear that the responsibility of children to care for aging parents resides primarily with them and should only be taken over by the state when such care is beyond both personal and familial efforts or resources.

The delivery of just health care to the elderly must therefore (1) pay attention to the responsibilities of both adult children *and* aging parents. (2) It necessitates a type of care that looks to motivation and performance (perhaps best offered by family members). (3) It gives priority to the dignity, participation and interdependence of all persons involved in care, and (4) assumes a view of social life that respects the status and competencies of individuals who work together within a society.

As indicated at the beginning of this chapter, the two issues canvassed here provide an appropriate bridge between the wider philosophical and theological discussions of Parts II and III and the historical reality of health care for aged Australians. It has become evident throughout this thesis that the two issues of justice, namely the age criterion and intergenerational obligations, gained prominence in bioethical discussion because of the particularities of the U.S. health care scene. The issues have served a purpose, however, in moving justice concerns in health care delivery from a narrow preoccupation with rationing to a wider consideration of limits. The rationing discussion in the U.S.A., in keeping with the prevailing American ethos, narrowed analysis to quantified, material or commodity notions of health care. Perceptions of health care as a social good were thus undermined. The age criterion and the question of intergenerational obligations, or *pietas*-as-Christian-responsibility, have moved the agenda from the rationing of things to the wider human experience of limits and the values at stake. For this reason alone the issues have served an important role in advancing bioethical reflection. Informed by the justice perspectives arrived at in this chapter it is now possible to use the lenses

ground and refined through the study of Parts II and III to view the issue of just health care for aged Australians that began this study.

9.3 SUMMARY AND CONCLUSIONS

9.3.1 Summary

Chapter 9 first considered the age criterion for health care delivery and rejected it as being inadequate and unjust. On the basis of earlier understandings of the place vision has in the moral life (chapter 6.1.3) and the particular vision of aging and well-being developed in chapter 7, it was possible to show from an understanding of the human person and justice as preferential option for the poor developed in chapter 8 that the age criterion has been a misguided response to the experience of limits in the human community. In the second part of chapter 9 the inadequacies of the bioethical discussion of intergenerational obligations (chapter 5) were overcome by the Christian virtue of *pietas* and an understanding of *responsibility* in Christian moral reflection.

9.3.2 Conclusions

Two conclusions have been reached in chapter 9.

1. On the basis of the understanding of the human person and justice as preferential option for the poor, I argue that public policy ought not implement an age criterion governing health care. Such policy is misguided in its understanding of limits and unjust in its implementation.

   On the basis of the understanding of the human person and the common good in Roman Catholic moral thinking, I argue that obligations in adult child-elderly parent relations are minimal requirements for familial and social life. I further argue that a more comprehensive understanding of obligation as *responsibility* acknowledges, in a more richly textured fashion, the personal obligations of adult children to their parents and recognises the obligation of the elderly vis-a-vis their family and the wider community.

CHAPTER 10

JUST HEALTH CARE FOR AGED AUSTRALIANS

10.1 Content 477

10.2 Conclusions 480

- 10.2.1 At the Political Level 480
- 10.2.2 At the Level of General Ethical Theory 481
- 10.2.3 At the Level of Justice 482

10.3 Implications 483

- 10.3.1 For Aged Persons 484
- 10.3.2 For Health Care 486
- 10.3.3 For Just Health Care 488

10.4 Proposals 489

- 10.4.1 New Policy Initiatives 489
  - 10.4.1.1 Community Aged Care Packages 489
  - 10.4.1.2 Residential Care for Aged Persons 490
  - 10.4.1.3 The National Carer Action Plan 491
- 10.4.2 Reflections and Proposals 491

PART IV

CONCLUSIONS, IMPLICATIONS, PROPOSALS

CHAPTER 10

JUST HEALTH CARE FOR AGED AUSTRALIANS

This thesis has explored three substantial areas: Australian aged care, bioethical and theological analyses of just health care for aged persons. In the introduction to this study I set myself three objectives. The first was to redefine the justice questions considered initially in chapter 5. The second was to indicate a number of implications for health care for aged persons on the basis of the study undertaken. The third was to put forward proposals that might contribute to the development of Australian policies for justice in the health care delivered to aged persons in our country. On that account chapter 10 is divided into four sections. A brief synopsis of the thesis (10.1) introduces the set of conclusions that arise from the three levels of reflection foreshadowed early in this study (10.2). At the end of each chapter throughout the thesis I have indicated a number of conclusions which now become the basis for outlining a set of implications arising from this inquiry into just health care for aged persons (10.3). Finally, in a very brief consideration I sketch some proposals for enhancing policies directed to just health care for aged Australians (10.4).

10.1 CONTENT

Chapter 1 surveyed the place of the elderly and the issue of aged care in Australia up until 1991-1992. On the basis of past, present and future demographic trends, the economic, housing, health care and community service dimensions of aged care were explored. In light of these data I suggested a number of critical comments that might be profitably recalled at this point. Australian aged care has focused principally on age-as-chronology. Little or no attention has been given to the subjective dimensions of the aging process be that for the individual or the nation as a whole. On the other hand, great attention has been given to self-reliance. Arguments about the distribution of the aged pension illustrate this.

Closely connected with this concern has been the liberalism prevailing in Australian society, which has given high priority to the role of personal autonomy. Discussion of aging has mainly been concerned with human functioning and capacity and little concerned with wider matters of aging. I have suggested that this has been the case primarily because there has been no clear vision of what it means to age in Australian society. Apart from a short period in the late nineteenth century the elderly have not been a significant group within this society until now. Through most of the twentieth century Australia has viewed itself as a young country. The rapid expansion of the nation, its population and its infrastructure in the decades following the Second World War was assisted by abundant employment, a vigorous work ethic and growing prosperity. Preoccupation with employment and wealth, and in more recent times with unemployment, have contributed to a negative, even pessimistic view of aging within Australian society. Once a person retires there is little to do apart from an active leisure period which effectively prolongs middle age until the limits and disabilities of aging close in. There has been a radical failure in late twentieth century Australian society to name, delineate and explore the profound human issues that aging brings to individual citizens and to the body politic.

Two social factors have been significant throughout the period considered. First, a concern with social justice issues has ensured that the elderly were part of the public agenda, even if this entailed only minimal financial support and piece-meal health or community services. A preoccupation with technical responses and pragmatic solutions has characterised the communal response to the elderly during Australia's relatively short history. Second, the issue of aging must be viewed in the wider social context of changes in Australian family life. The changing social profile of family life has made the issue of intergenerational obligations as pressing a problem in this country as it has been in the United States. With the Home and Community Care program age has ceased to be a criterion in health and community services. In its place need has become the ground for claims on the wider community. Chapter 1 presented the view that aged care in Australia, rather than being a single or isolated issue, is best understood as a tapestry of interconnecting issues.

In light of the gaps that exist in Australian aged care policies chapter 2 introduced an alternative line of inquiry. I judge a humanistic approach to be more attentive to the interconnecting network of factors related to aging and health care, especially the problematic human issues arising from individual and societal aging. Central to the inquiry is the question of *meaning* concerning aging itself: What does it mean to grow old? I have argued that narrowly focused or reductionist explanations of senescence inadequately address the fundamental human quest for the meaning of

longevity. Two further problematic issues were next investigated: What does it mean to be healthy or ill when one is aging? What does it mean to care when aging brings chronic illness, disability and long term questions of care? The issues of well-being and care have a different complexion and implications when elderly persons are involved. I concluded at the end of chapter 2 that a comprehensive exploration of aging, such as that suggested by enlightened humanistic reflection, offers a more satisfactory approach to the issues of health care for elderly persons than is to be found in the merely technical or pragmatic responses of recent Australian aged care policies.

Having sketched the historical context and indicated a number of defects in Australian society as it confronts an increasing proportion and number of aging I then moved to consider two types of ethical response to the issue of just health care for the elderly. Part II in chapters 3 to 5 provided a bioethical perspective, Part III in chapters 6 to 9 a theological analysis. A similar methodology was employed in both sections. From more general background material in chapters 3 and 6 each part of the thesis moved to the substantial ideas proposed from philosophical and theological standpoints. In the bioethical discussion chapter 4 outlined the contributions of the two American bioethicists, Norman Daniels and Daniel Callahan. Each represents distinct philosophical approaches to political life and contemporary medicine. Daniels developed his justice thinking on the basis of John Rawls' justice-as-fairness theory and applied it explicitly to the justice questions involving health care for the aged. Daniel Callahan undertook a more wide-ranging analysis. At one level he attempts to challenge American society to re-think its basic values: from being a consumerist and high tech society to one that acknowledges limits in all areas of human existence. With this in mind Callahan proposed that age be a criterion for health care delivery. Chapter 5 explicitly considered two issues of justice arising from the experience of limits in health care delivery: the age criterion and intergenerational obligations. Serious defects were observed in the bioethical analysis.

The theological analysis of Part III mirrored the bioethical study of Part II. Having established the relevance of Roman Catholic moral theory for the topic being studied in chapter 6, the following chapter revisited the three *meaning* questions considered from a humanistic perspective in chapter 2 and *framed* them within a number of theological givens. An understanding of aging is not only framed but also transformed by notions of human life and death. Well-being as a matter of both health and illness is transformed when considered in the context of human bodiliness and an understanding of pain and suffering. Care is likewise radically altered by a

view of Christian charity or *agape* that emphasises both personal motivation and personal performance. The three key ideas of the human person, the common good and justice as preferential option for the poor were presented in chapter 8 as satisfactory keys for opening the two justice issues to resolution.

Parts II and III had a similar structure best imaged by the shape of a funnel. Chapters 5 and 9 were envisaged as being at the bottom narrow portion of the funnel, the point towards which the preceding bioethical and theological inquiries were directed. The age criterion was proposed by Callahan, albeit in a highly restrictive form, and endorsed cautiously by Daniels. Theologically, this proposal was judged to be misguided in its understanding of limits and unjust should it ever be implemented. A satisfactory analysis of the obligations incumbent on adult children to care for aging parents eluded Anglo-American philosophy. Unable to justify the obligation philosophers struggled even to describe the scope of the obligation. It is my argument that the philosophical response to the issue is fundamentally flawed. The richer textured theological analysis of intergenerational obligations in terms of *responsibility* gives a greater role to such duties in social life. Responsibility emphasises the multi-dimensional character of the inter-personal obligations. Use of the notion enables a theological account to include the aged within a covenantal community, treating them as equals and demanding a contribution from them in a manner appropriate to their age. Where aged persons are likely to be marginal in society Roman Catholic thinking argues for the claims of justice biased in their favour as the parable of the Good Samaritan demands. In this way factors that impoverish the aged may be redressed and they are enabled to be equal participants in the life of society.

10.2 CONCLUSIONS

At the end of Part I of this thesis I foreshadowed that three levels or strands of reflection permeate the discussion and analysis of Parts II and III. I now turn to a consideration of these three levels since they provide a filter and a framework for developing the conclusions of this thesis.

10.2.1 At the Political Level

In Australian civil life liberal thinking, together with a culture of pragmatism, has played a dominant role particularly in the area of health care. Implicit throughout this study has been my belief that the political environment has shaped and, to some

extent, dictated the questions and answers in the area of health care for the elderly. The analysis of liberalism and justice in chapter 3 provides ample evidence of the thinly textured notion of the good considered essential for the functioning of the liberal state. Competing views of the good, exceeding the minimal requirements for an overlapping consensus with which the liberal state functions, are relegated to the realm of personal choice or private preference. In chapter 6 I have argued that Roman Catholic moral theory has something to contribute to public discourse on justice, health care and the aged.

The neutralist presumptions of liberal theory effectively exclude communities such as the Catholic Church from contributing to aged care policies over and above the basic minima necessitated by the liberal ethos.[1] This is a pity since liberal government and administrative procedures thus impose limits that are ultimately detrimental to the good of Australian society, and to the elderly in particular. First, Australia as a liberal state is radically impoverished since it does not have the mechanism or the intellectual and community frameworks for incorporating ideas that diverge from the liberal norm. Liberal government is unable to deal in an adequate fashion with what might be of help to specific groups in the society. Second, the responsive and pragmatic nature of reaction to aged care needs through Australian history was shown to exclude in great part the humanistic set of considerations explored in chapter 2. At the political level, then, it is fair to say that the liberal theory and practice that dominate Australian health care are seriously defective because they deprive the entire community of resources and contributions for attaining just health care for aged Australians.

10.2.2 At the Level of General Ethical Theory

Placing recent bioethical analysis of just health care for the aged alongside a theological study has brought into focus my claim that Roman Catholic moral theory not only has something substantive to contribute to public discussion and policy development but also offers the elements for resolving some of the key dilemmas associated with just health care for the aged. The liberal thinking of Norman Daniels shares the defects outlined above in regard to the liberal state. I recognise that the central liberal emphasis on rights and autonomy which give priority to the individual have contributed enormously to the development of Australian society and its health care system. It is important that the advances derived from liberalism not be lost in

[1] The theological struggle over Catholic identity referred to in chapter 7.3.4 has been precipitated by this fact: How does a community, seeking to offer more, confront the minimalist imperatives of the liberal agenda?

future developments. Even in the communitarian thinking of Daniel Callahan the presuppositions of liberalism are strongly evident, especially when he discusses the type of health care system appropriate to the U.S.A. The thinly textured nature of liberal thinking falters because it excludes a frame of reference and substantive key ideas.

Chapters 7 and 8 have argued that Roman Catholic moral theory offers such a frame of reference which transforms our understanding of growing old, well-being and care. The key ideas of the human person, the common good and justice-as-preferential-option-for-the-poor are thickly textured notions and sufficiently comprehensive since they attend to the role of the individual (the human person), the community (the common good) and right relations between both (justice as preferential option for the poor). While much of the substantive contribution of Roman Catholic moral theory is congruent with the humanistic reflection of chapter 2 it is shaped by the teaching and life of a particular faith community. In a pluralist society this should not necessarily put the Roman Catholic contribution beyond the reach of others who do not share their faith convictions. The natural law tradition of the Church has argued that there are core moral notions that are vital for conscientious living even if a person does not have faith. In this natural law context, the framing elements transforming the problematic questions of life, death, bodiliness, pain, suffering and charity may be utilised, even when isolated from their specifically theological dimensions. This is also possible for the key ideas studied in chapter 8. Notions of the human person, the common good and justice as preferential option for the poor may likewise be utilised in a leaner non-theological way. I have argued throughout that these framing elements and key concepts are essential for a satisfactory appraisal of just health care for the elderly.

10.2.3 At the Level of Justice

The practical effect of the theoretical proposal just outlined is demonstrated clearly in the two justice questions of the age criterion and intergenerational obligations. The influence of the theological framing and key ideas have been articulated in chapter 9. Roman Catholic moral theory offers more adequate answers by excluding the age criterion proposal from the arena of health care delivery. The frameworks elaborated in the theological analysis undermine many of the presuppositions that generated the American discussion in the first place. A more realistic understanding of limits that encompasses human life from conception to death, and that acknowledges the narrowed capacities in growing old and the burden of pain and suffering arising from aging bodies are but some of the factors canvassed in this thesis. I argue that these

factors effectively undermine the terms within which the issue was originally raised in U.S. health care. The same may be said of intergenerational obligations.

Philosophically the nature and scope of familial obligations were inadequately addressed both by the liberal Daniels and the communitarian Callahan. The covenantal community of the Christian tradition provides a framework for understanding relations within the family. In Roman Catholic moral theology mutual and participative relationships are central to the notions of personhood and common good. Most dramatically such fellowship is seen to be present in the life of the Trinity which is the model and ideal for community. From the earliest breakthrough of Ezekiel 18 in the Old Testament, individual responsibility for one's life and relationships within the covenant community and society have been at the heart of Christian teaching on the moral life. One important implication for just health care for the elderly requires that elderly persons are never to be considered solely as recipients of care. Rather, the Christian notion of vocation and the call to live virtuously necessitate the understanding that every person has something to contribute to the good of the community. Very little has been written in contemporary literature about the obligations of parents toward their children and the wider community. In a world where aging has little meaning and where the elderly are marginalised in society, becoming old has been portrayed in terms of disengagement, decay of bodily and spiritual capacities and a life of passivity. Roman Catholic moral reflection rejects this line of thinking. Each and every person has a responsibility, according to their age and capabilities, to build life in common. Responsibility thus enlarges the parameters of the philosophical focus on duty or obligation and locates it within the rich and varied sets of relationships that constitute social existence.

10.3 IMPLICATIONS

In 10.2 above I put forward a number of important conclusions that arose out of the study undertaken in this thesis. Because this investigation has traversed an extensive landscape of issues and research it is also possible to indicate a number of significant implications of this inquiry for just health care for aged persons. These are to be found scattered through the text and concretely expressed in the conclusions at the end of each chapter. The title of this work designates three areas where implications should be drawn: implications for (1) aged persons, (2) for the health care offered to aged persons and (3) for the justice dimension of this health care. It is to these I now turn.

10.3.1 For Aged Persons

This study makes clear that there is no consensus regarding the social role elderly persons have in Australian society. No commonly held opinion exists as to what it means to grow old in a liberal, pragmatic and activist society such as ours. Equally evident from this study is the fact that meaningful and clear social roles are inextricably linked with the values, expectations and structures of society. As noted earlier old age confronts a society and ethos that values employment and productivity as *the* criteria of individual identity. Discussion of disengagement theory and dependency ratios all have the issue of productivity lurking in the background. When, through the passing of the years, an individual leaves the workforce and experiences periods of dependence it becomes obvious that a coherent and meaningful vision of old age is needed. Frequently the aged person is judged to be a burden on family or society and a nuisance demanding time, energy and money of those "getting on with the job" of developing the economic future of the nation. In light of this I accept Daniel Callahan's thesis that a re-appraisal of the fundamental values underpinning liberal society is imperative and is as necessary for us in Australia as it is for Americans.

One step on the way to a national re-evaluation of the status and role of aged persons in Australian society is to be found in the proposal that we move beyond the problem-framework of a liberal approach and begin to think in terms of the *mystery* of growing old. The nature of aging as a human experience and phenomenon leads me to conclude that this would open up the question of aging to a broader range of understandings. Two of these have been outlined in the course of this thesis from a humanistic and theological perspective. Although liberal social theory and practice has great difficulty in acceping the mystery dimension of old age, I suggest that the very character of the pluralism essential for a liberal society predisposes to such an outlook. The variety of opinions permissible in liberal society makes it possible for an almost unlimited range of perspectives to develop about what it means to become old whether individually or as a society.

Repeatedly throughout this study an emphasis was given to a wholistic approach to aging and issues associated with being old in society. The "whole-picture" dimension is demonstrated by (1) the total life span view and (2) by emphasis on the community context of aging. A total life span view is to be found in the Christian moral vision which insists on valuing human life throughout its existence and on a conscious acceptance of the reality of death. I argue that these two awarenesses have a direct affect on human behaviour. Most importantly they exclude any conduct that threatens human life or seeks to exclude the reality of death. This has direct implications for an

aging society. It demands a respect for persons at the end of life's journey. On the one hand it excludes futile or burdensome efforts to extend an aged life and on the other hand prohibits disposal of such human lives because they are judged unduly burdensome or costly.

Catholic moral theory takes a broader communitarian view when addressing the role of the aged. The theological understanding of moral responsibility presented in this thesis emphasises each person's responsibility to live fully at every stage of life. In the journey of life each stage directly prepares for those that follow. Ultimately life is a preparation for final union with God. Such responsibility is expressed in the duties aged persons have to their families and to the rest of society. They have something to offer to others for the common good. It has been noted already how little attention has been give to this in contemporary literature. Not only must greater emphasis be given to articulating the responsibilities of the elderly in and for society but much greater attention must also be given to the virtues we wish to be present in old age. Portrayals of aged persons as role models offer a vision which, hopefully, will inspire younger people when they become old. Recent films such as *Driving Miss Daisy* are beginning this process.

One practical implication of a specifically communitarian vision of aging is the rejection of any process of social segmentation that isolates one age group from the wider community. I believe this has a detrimental effect on the life of the community depriving it of the rich contributions that all age groups can make to the spirit and culture of society. Where the elderly are isolated from the mainstream of social life there takes place an effective depreciation of old age within that society and an impoverishing of the wider community. Younger generations miss the opportunity of seeing their present life as directly linked to and preparatory for their later years. Because of this health care for aged persons must be immersed in a community that is multi-generational and in which daily contact between all aged groups is a reality.

The dominant paradigm pervading many of the issues of aging studied in this thesis is that of age-as-chronology. While every effort is being made to remove age discrimination from public life in Australia chronological age continues to be a dominant influence in many areas of social life. Little or no attention appears to have been given, particularly in Australian literature, to the subjective dimensions of aging. Some of these subjective aspects were sketched briefly in the course of this study: awareness of passing time, the experience of increasing limitation and of loss, awareness of mortality. Four aspects of the experience of old age were also developed in slightly greater detail. No effort was made to present a comprehensive

description. The four elements considered suggest areas for further reflection and development. The role of *time* was seen to contribute to a richly textured three dimensional human existence. The experience of *dependence* acknowledges human interdependence and solidarity. *Poverty* brings an awareness to the old person that he or she is a limited creature. Enjoying *leisure* can contribute to the spiritual, cultural and civic enrichment of the individual and the wider society. These four values highlight the responsibility aging persons have in today's society to reflect, write about and share insights into their own experience of growing old. This implies that a richer understanding of growing old is best articulated by those already in their latter years. Their duty, I suggest, is to communicate it to the rest of Australian society. The recent flowering of oral history, family histories and genealogical investigations gives hope that spiritual, cultural and civic aspects of Australian social life will be given their rightful place. This will in turn enchance the status and contribution of aged persons for the good of all in our society.

10.3.2 For Health Care

The shift from an age to a need criterion in the delivery of home and community care has been an important one in recent Australian public policy. Need is a somewhat elastic notion and must be clarified for public policy to be fair. An uncritical concentration solely on need may, in time, cause a conflict between particular groups within our society as has occurred with intergenerational conflicts in the U.S.A. This implies that much public discussion is required to do two things: to delineate an adequate definition of *basic needs* and to decide on the responsibilities society accepts in its care of individuals and groups. Among the practical implications flowing from this is a clearer picture of the basic care all Australians can realistically expect in the national health care system. It will assist a clarification of the expectations associated with the care of aged persons in our society.

A psycho/social/somatic/environmental view of health favours a wholistic framework with direct implications for health care for the aged. Not only does it effectively de-medicalise notions of aging, health and illness, it also gives importance to the bodiliness of the aged person and his or her well-being. It focuses on the bodily character of the art of healing, on the physical presence of the professional health care giver and on the type of caring given and received. Human embodiment constitutes an important arena for assessing the issues of justice, health care and aging. In a society deeply attached to bodily beauty and the capacity to function fully human bodiliness is frequently viewed as an instrumental value. In this study I argue that a theological perspective recognises that an aging person's body is

the privileged locus of care and attention. This applies no matter how limited, handicapped, disfigured or decrepit the person may be. The body of the elderly person is viewed sacramentally in Roman Catholic theology. The bodily person is seen as capable of revealing mystery, especially the mystery of God.

A further implication of a wholistic understanding of health and illness, well-being and healing attaches great importance to the realm of the spirit. Aging confronts humans with the reality of mystery in a new way and places the spiritual questions of meaning, such as those explored in the humanistic and theological sections of this thesis, to the fore. Health care for aged persons insistently urges an acknowledgement of the spirit and matters of the spirit as is to be seen in the earlier study of chronic illness, pain and suffering.

Caring for another demands an attitude of mind such as solicitous concern and, at times, effective actions on behalf of another person. The correct ordering of the different dimensions of care has direct implications for the type of care offered to aged persons in contemporary society. Where care has the highest priority medical care and cure take their righful yet subsidiary place. The increasing incidence of chronic illness in an aging population requires that high priority be given to caring for persons for whom there may be no cure. This is perhaps the greatest challenge and contribution to health care that an aging society makes in the contemporary world. Not only is there a need for effective health care for the elderly, there is also required a range of other caring activities such as attending to personal needs and providing social services that enhance the aged person's quality of life. The notion of care, when given its central place in the human community, significantly orders a wide range of human activities.

The theological dimension of caring presented in this study adds a further important perspective. It suggests that care involves not only practical solicitude for the needs of the neighbour but also a degree of personal commitment and a certain interior dispositions of mind and heart. The parable of the Good Samaritan dramatically illustrates the qualities of care in the Christian scheme of things. Care viewed in the context of divine covenant fidelity emphasises the giving of what one has first received. This occurs in the context of mutual interpersonal relations between equals. In light of this understanding I argue that the notion of agape as Christian care implies a particular quality of care. Caring for aged persons, those who are chronically ill or disabled, requires a personal level of involvement that may, in time, transform our understanding of health care. Emphasis will have to be given to the character, dispositions and fidelity of care givers in a way not before expected within

contemporary health care. If this insight is valid then many of the formal requirements for a just and liberal society may undergo change. It is fair to expect that a more thickly textured understanding of health care will result.

10.3.3 For Just Health Care

Concern for social justice and a basic standard of living have been important priorities in Australian social history. The safety net role of pensions and concern for the quality of life dimensions of home and community care have been significant positive values in our society. These values are presently being assaulted by a number of social changes. Reference was made briefly at the end of chapter 1 to the changing profile of Australian families. From the discussion of intergenerational obligations in chapters 5 and 9 it is obvious that such changes will have a direct impact on the scope of the obligations expected of adult children vis-a-vis their aged parents. Although it has not been possible in this thesis to explore the sociological changes taking place in contemporary Australian families, it is important to note here that such changes have significant implications and ramifications for the justice of intergenerational responsibilities.

Early in this study I observed that a coherent aged care policy has been slow to develop in Australia. Throughout this inquiry it has become evident that just health care for aged Australians must be viewed as existing within a tapestry of inter-connecting issues. A consequence of this is that policy proposals dealing with health care for aged Australians must always be linked to the larger range of issues considered in the preceding chapters.

Finally, I urge the significance of the theological understanding of personal existence which is radically inclusive. Because humans are interdependent they are responsible for others. This responsibility, I argue, favours a view of justice that requires a bias or preference for those in greater need or who are on the fringes of society. Two things follow on this claim. First, policy proposals for health care for aged Australians must attend to the range of issues that effectively relegate the elderly to the periphery in an active and productive society. Such things as mobility, housing, post-retirement finance and a health care service that is wholistic in scope must all be taken into consideration. A second implication arises from a common good perspective. Priority must be given to the social conditions that enhance the dignity of the human person in community and enable each person to participate fully in and for the common good. This is only possible when equity and equality are effectively implemented regarding the basic goods of social life. Aged persons can only

contribute when their status, role and responsibilities are assured through their inclusion and full participation in the life of society.

10.4 PROPOSALS

10.4.1 New Policy Initiatives

This inquiry has explored the issue of just health care for aged Australians up until 1992. Australia voted in a change of government in early 1996. The Liberal-National Coalition Government has, since coming to power, made a number of significant declarations of new directions and intent in regard to health care for aged Australians. The dominant role of economic rationalism and small "l" liberalism are presently changing the shape of social and health care policies from that which prevailed under the previous Labor government.

The government announced its *Aged Care Structural Reform Package* in the 1996 Budget. Three areas were given high priority: (1) Community Aged Care Packages, (2) residential care for the elderly, and (3) funding for carers through a National Carer Action Plan. On the February 10, 1997 the Hon. Judi Moylan, Minister of Family Services, published a statement *Steps to Better Care. Implementation of the Government's Residential Aged Care Structural Reform Package.*[2] This text and the later information pack offer a brief summary of the new orientation and directions. At the end of an already long thesis I shall simply outline three core elements of the Aged Care Structural Reform Package. The transition from policy to implementation is only just beginning at the present time. For that reason the critical reflections and proposals I make below must be judged as work in progress. Nevertheless, they serve a purpose by indicating the continuing relevance of the issues canvassed in this study and by suggesting a number of areas where Roman Catholic moral thinking might contribute to the development of just health care for aged Australians.

10.4.1.1 Community Aged Care Packages

Community Aged Care Packages are directed to assisting aged persons who live in the community to remain at home by providing a range of services, such as bathing, meals, transport, shopping, to meet their care needs. The packages are provided by

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[2] *Aged and Community Care Fact Sheets Nos.1-24* published by the Commonwealth Department of Health and Family Services on 28 May 1997 are the basis of what follows regarding current aged care reforms.

community organisations and funded by the Commonwealth Government. Aged Care Assessment Teams determine the level of care needed and whether a care package is suitable to the elderly person. The services provided are intended to be flexible, changing as individual needs change.

Difficulties arising from Commonwealth-state government relations in the implementation of the earlier HACC program appear to be one of the factors giving momentum to this new approach.[3] Emphasis is now to be placed on *care managers* who are responsible for delivering services to clients. Funding has shifted from *input* to *output*. Funding for the HACC program has been directed primarily at the *input* area. This has resulted in a disproportionately large proportion of federal funding being absorbed by the structures set up to deliver the care. A focus on *output* seeks to overcome this problem and targets expenditure directly to needy individuals.[4] One obvious danger in this shift of emphasis is that services which accomplish high output will be favoured as has occurred with the fee-for-service regime in Medicare.

10.4.1.2. Residential Care for Aged Persons:

The *Aged Care Bill 1997* is at present implementing a nation wide reform of hostels and nursing homes.[5] Central to the reform is the concept that the cost of residential aged care should be borne in part by the person requiring care. A shift of focus is being proposed that no longer views nursing homes as part of the health care system. The national health care scheme, Medicare, distributes the cost of providing health care services across the entire community. Equality of access to publicly funded health care is a central principle of the scheme. Residential aged care, however, is now to be viewed as part of the welfare system which has always means tested recipients of benefits. Residential aged care, the government argues, involves a choice about housing. For that reason relocationg to an aged care facility is primarily a choice about residential accommodation.

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3 Mr. Warwick Bruen of the Commonwealth Department of Health and Family Services informed me in an interview on July 16, 1997 that funding of HACC was intended to achieve a 6% rate of growth. In reality services increased at only 3% during the past year. Future projections now envisage a 3.5% growth in the program from government funds, the remaining 2.5% will be generated by fees on the basis of "user pays".

4 At the present time *output* is the benchmark. *Outcomes* are still considered too difficult to delineate and quantify in the area of home and community care.

5 The *Aged Care Bill 1997* is the principal legislation initiating structural reforms in aged residential care. It sets out the broad framework for the entire aged care program, other than the HACC program. Four further bills (Consequential Provisions, Compensation Amendments, Principles, Income Testing) ensure the implementation process.

A number of details in the changes merit mention here. Nursing homes and hostel accommodation will now be funded according to an eight level scale: categories 1-4 represent high care levels, levels 5-8 indicate low levels of care. On entry an aged person is expected to pay an accommodation bond which will be used for the improvement of the residence. Income-tested daily fees are also to be applied to residents. Part-pensioners and non-pensioners are to be assessed in the same was as applicants for the age pension. Government control of accommodation for aged persons is directed to ensuring fair and balanced distribution of residential services across regions with a target of 90 residential places and 10 community places per 1000 people 70 years and older. As with community aged care packages entry into residential accommodation is to be determined by Aged Care Assessment Teams. The government is presently assuring an anxious aged sector that access to nursing home and hostel care is to be based on need for care and not on capacity to pay. To achieve this providers of residential care are expected to have a stipulated proportion of residential places for concessional residents.[6]

10.4.1.3 The National Carer Action Plan

This plan gives support and assistance to the carers of people in the community who are not able to manage alone because of illness, disability or frailty. There are about 540,000 principal carers of people with severe or profound handicap in Australia. The plan focuses on improving (1) information, assessment and support needs for carers, (2) respite services and (3) financial support for carers.

10.4.2 Reflections and Proposals

The liberal pedigree of the new government's initiatives is manifest in the attention the reform package gives to the individual as the recipient of service delivery. On a number of points the intent of the reform may be judged to be good. The focus on improvement of the physical accommodation of hostels and nursing homes, to a level appropriate for aged persons, is a correct one and much needed. Likewise the shift of aged care from the health care arena to a welfare situation has important implications. Hopefully it will contribute to the de-medicalising of old age and a more wholistic understanding of the well-being that aged persons should expect. The justification of accommodation bonds for new entrants into nursing homes also appears *prima facie* to be convincing.

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6 Other issues such as user rights, quality assurance, accreditation standards, appropriate staffing, prescribed services, certification of facilities need not delay us here.

In a critical vein I suggest the new proposals continue the reactive policy approach that has existed in Australian health care for a long time. The liberal emphasis on structures and processes such as accreditation and quality control, laudable as they are, still leave aside broader humanistic considerations. Financial leverage appears to be the primary instrument for bringing about change to aged care in this country. Nothing has been said thus far, as part of the introduction of the scheme, about the type, quality and scope of care that aged persons can expect of individuals and society during their dependent years. The only responsibilities placed on elderly persons in the new regime are for aged persons to contribute financially to the care they need. I suggest that a clearer picture of what is to be expected of the aged would contribute not only to the quality of their lives but to the general spirit of the wider community.

While need for care is the professed benchmark for entry into aged residential accommodation, the actual implementation of the scheme leaves a host of questions. The way in which concessional residency for persons who are on a pension and who are unable to contribute financially to for-profit nursing home accommodation suggests that equity and equality of access will be under pressure and even that a two-tier system will eventuate.

In light of these concerns I suggest that the Roman Catholic community and its health care system has much to contribute to further development of just health care for aged Australians. A greater effort will need to be made to broaden the narrow liberal agenda of the present government by ensuring emphasis be given to broader communitarian issues. The conclusions at the political level presented above in 10.2.1 retain a continuing validity for the aged care reform program. The three meaning issues canvassed in detail in this thesis, namely aging, well-being and care, must be given higher priority in public discussion about health care for aged Australians. The justice of any policy implementation in the future must not envisage provision of nursing home accommodation simply in terms of an individual's prudential planning for future needs and dependency. The issue of provision of accommodation for aged persons especially in hostels and nursing homes is inextricably linked with financial savings made during the years of employment and the superannuation or age pension regime following retirement. If aged persons are to be included more effectively in the life of the community there needs to be an explicit acknowledgement that society will shoulder the burden of care for persons who have not been prudent in their lifestyle or planning and who may, in their old age, be totally dependent on others. When this is assured Australia will have taken one step on the road to assuring just health care for aged persons.

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