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Aging Well in 21st Century America: Towards a Theological Ethics of Aging

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LOYOLA UNIVERSITY CHICAGO

AGING WELL IN 21ST CENTURY AMERICA:
TOWARDS A THEOLOGICAL ETHICS OF AGING

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN INTEGRATIVE STUDIES IN ETHICS AND THEOLOGY

BY

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INTRODUCTION

THE GOOD LIFE AND THE THIRD AGE

For most people, retirement marks a transition into a ‘third age’ of one’s life, a time of enormous change. No longer needing to set an alarm clock is the least important, but perhaps first significant change one may look forward to. It signifies not needing to be somewhere, not needing to do something, not having a particular responsibility. It is a small indicator of a new and profound condition of freedom. However, persons transitioning into and developing through the Third Age are confronted with various images that try to model how that freedom should be expressed. These images present opportunities for Third Agers to assimilate or develop authentically, to follow socially constructed patterns of behavior, or to flourish on their own terms. The normative images for the Third Agers allow them to either envision and live their *new* life, or adopt a course set out for them. These new lives require a re-discovery and re-defining of the self, a reinterpretation of one’s role in society, and relationship to others. As with other phases of life, individuals need guidance when confronted with images of living well that are contradictory or perhaps antithetical to what they imagined for themselves. Various social and cultural practices and beliefs limit acceptable modes of self-expression for the retired person. The current economic climate complicates what is meant by a ‘retired person,’ so first a word on the subjects of this dissertation.

The aging population is popularly associated with the language of senior citizen, the image of the nursing home, and, in biomedical ethics, the end of life. It is true that aging persons, at some point, fulfill these images, but it is not fair to generalize all aging persons so narrowly. Yes, we are all aging, but there are differences between the aging person at 25, 45, 65, and 85. In a seminal article that tries to parse out the distinctions between phases of aging, Bernice Neugarten explains that there exists an increasing amount of differentiation among various age groups, particularly those to whom we would refer as aging or older persons. In articulating different phases or *ages* of life, in accord with the medical and psychological developments of the time, Neugarten turns to the indispensable marker of chronological age to help explain how there might be differences in aging persons. The young-old, as she identifies them, are those who are between the ages of 55 and 75, and those who are 75 and older are classified as old-old. Neugarten admits an overlap in middle age and the young old, but she cites that the lowering of the retirement age in the US precipitated a shift to a lower age.¹ That more inclusive age group, believes Neugarten, is comprised of people who “are relatively healthy, relatively affluent, relatively free from traditional responsibilities of work and family, and who are increasingly well-educated and politically active.”² Following in the footsteps of Neugarten are other social scientists who settle on another term to describe this broad period of adult life, the Third Age. The Third Age can simply be defined as “the period of healthy retirement in later life.”³ For the purpose of this dissertation, the so-called aging person is to be understood as someone who falls

¹ Neugarten, Bernice L. 1974. “Age groups in American Society and the Rise of the Young-Old,” *The Annals of the American Academy of Political and Social Science* 415 (1): 187-98. 191.

² Neugarten, “Age Groups in American Society and the Rise of the Young-Old,” 187.

³ Carr, Dawn C., and Kathrin Komp. *Gerontology in the Era of the Third Age: Implications and next Steps*. (New York, NY: Springer Pub., 2011,) 4.

into the Third Age or who can be classified as Neugarten's young-old. From this point forward, the terms "the aging" and "Third Ager(s)" will be used interchangeably.

Achieving the good life, whether that be in the Third Age or another phase of life, has been a subject of philosophical inquiry since the Ancient Greeks. Plato and Aristotle spoke of living well as an activity of the soul, an active pursuit orienting the whole person. Stoic philosophers emphasized the role of reason in the pursuit of the good life and believed that living the good life required adhering to the laws of nature as well as living virtuously. Aquinas, Locke, Mill, and others all described a vision of the good life and outlined how humans might achieve it. However, translating the abstract metaethical notion of the good life into normative claims is, of course, not simple regarding the lived experiences of individuals. Because human experience is mediated through various social imageries, normative claims derived from abstract notions of the good life limit the individual's opportunity for self-reflection, self-knowledge, freedom and therefore, living an authentically good life as it is defined in modernity. This ontological problem must be addressed by philosophical ethicists, but is not the focus of this dissertation. Instead, I wish to highlight here this project's place as an example of the type of interpretive analysis that is born of the tension between metaethics and normative ethics. The dissertation demonstrates this problem by exploring the social imageries of aging well presented to Third Agers. So how then are the limits of normative claims vis-à-vis social imageries revealed in the Third Age?

Using Aristotle's notion of happiness, namely the life that the individual wishes to lead and is a pleasing activity of the soul as the broadest vision of the good life, a quick search will show that a number of normative frameworks offer the Third Ager imageries (or ways) to be happy. Defining a more specific vision of good life for the Third Age cannot and will not be done in this dissertation, because of the ways in which the lived reality of the Third Age (and

years before that phase) contextualize the individual's understanding of the self and of the good. Narrowly focused normative visions of the good life in the Third Age present a practical problem to the diversity of Third Agers in the US; that is, not everyone will have an opportunity to pursue any one vision of aging well today. Narrow visions also limit how Third Agers come to learn what living well means; they inhibit authentic modes of knowing and expressing the self. Of particular importance is the fact that contemporary visions of the good life in the Third Age are informed by or emphasize autonomy, yet those visions undercut the authenticity of autonomy by limiting its range of expression.

In a pluralistic society, proffering a singular normative vision is impossible precisely because it would be unable to account for the diversity of individual beliefs, values, and moral systems. Moreover, a normative vision of the good life would impose a particular way of life upon others, thereby undermining their own autonomy. Despite the problem of plurality, the models examined in the dissertation are rather specific in identifying what will bring about or enable an individual to live the good life. Because these visions of the good life pervade the social, cultural, and political landscape of the US, they often remain unchecked, leaving the targeted group conflicted by what is and how to pursue the good life. Thus, the dissertation analyzes and responds to these responses and proposes an ethical framework to be used moving forward when considering the good life in the Third Age.

In the first chapter, I explore the ways in which medicine, gerontology, and medical ethics consider the question of aging well. A brief overview of the relationship between health and the good life will be provided before delving into the modern claims of medicine, gerontology, and medical ethics. The discussion of medicine and aging well will reveal medicine's limitations in conceptualizing aging well as having an optimally functioning body

and mind, or simply as healthy aging alone, which shapes the discourse within medical ethics insofar as aging is understood as a natural process or a disease to be treated. A foray into the parallel developments within gerontology will show how the Third Age can be a fruitful time in one's life and should not be viewed with the negative perceptions that emerge from certain medical ethicists.

Building from the theme of healthy aging identified in chapter one, the second chapter addresses several social and cultural forces that inform notions of aging well in 21st century America. Consumer culture will provide the context for the discussion of the Third Ager's pursuit to live the good life. Being productive and consuming as means of maintaining or reforming one's self-identity is addressed as is the concept of autonomy and its connection to individualistic independence. The chapter shows that the political and cultural landscape of the United States, intertwined with the US capitalistic economic system plays a significant role in how notions of the good life in the Third Age are shaped.

In order to begin to respond to the imageries of aging well, enforced by a consumer culture that promises postponing aging through medicinal products and cosmetics, Chapter Three turns to theological sources that consider the good life in aging in a different way. A brief survey of biblical literature shows that the aging population was to be revered, afforded protections because of their vulnerabilities, and given a special status within the community. Contemporary theologians and ethicists follow in the biblical tradition insofar as they insist on care for the aging; Third Agers, however, are once again told that living the good life is largely a matter of their individual effort to remain productive. Faith and hope for the Third Ager represent one answer for how to age well; the other is by practicing specific virtues relevant to the Third Age. Integrity, generosity, humility, and friendship are but a few of the virtues identified as integral

for the Third Ager's navigation of this phase of life as he or she practices living well. Though helpful, appealing to virtues ethics as an approach to aging well reveals the profound problem posed by the pervasive nature of individualistic independence addressed in Chapter Two.

The fourth chapter begins the constructive process by turning to the communitarian approach of Alasdair MacIntyre and the Capabilities Approach (CA) of Martha Nussbaum. Both MacIntyre and Nussbaum critique the overemphasis on individualism and the misinterpretation of autonomy in American culture. Both present frameworks for conditions to enable a Third Ager's good life. MacIntyre and Nussbaum provide complementary models for aging well that recognize the naturalness and positive experience of communality and dependency (MacIntyre) and the importance of a range of fundamental freedoms in one's pursuit of the good life (Nussbaum). Structuring an environment in which these two frameworks can operate cooperatively becomes the task of the final chapter.

While MacIntyre's and Nussbaum's approaches are helpful because of their emphasis on dependence and basic requirements for flourishing respectively, they do not consider the obligations of individuals and institutions in enabling Third Agers to live well. In order to explain how dependency and the basic requirements of flourishing transcend the Third Ager's practice of virtues alone, the chapter develops a normative social ethics. This is accomplished by first introducing Onora O'Neill's interpretation of principles as duties or obligations, and second, through interpreting the principles of Catholic Social Teaching in light of the good life of and for Third Agers. Though not negating the importance of MacIntyre and Nussbaum's contributions to an ethics of aging, the chapter turns to a principled model as an overarching framework for an ethics of aging. The principled model secures the space that is necessary both for Third Agers to consider what the good life in this phase may mean, and for society to ensure their dignity and

actualize the care and solidarity that is necessary for Third Aged to flourish. By spelling out the normative framework that obliges the social institutions and structures of society in view of the Catholic social ethical tradition, the groundwork for a new ethics of aging is created.

CHAPTER ONE

AGING AND LIVING WELL IN MEDICINE AND MEDICAL ETHICS

Introduction

Aging well will always require a certain level of good health. Without an adequate measure of physical and mental health, fulfilling one's vision of the good life may be hampered or prevented entirely. However, health is a contributing factor to the good life, not the ultimate deciding factor (the exception being the absence of health, death). Yet, of the ways in which aging well is described, the various metrics of physical and mental health feature prominently. Oftentimes the good life for aging persons is reduced to a clinical diagnosis. Should a patient be diagnosed with living a not-so-good life according to the various measurements, a treatment is prescribed until the good life is achieved. Such a one-dimensional view of the aging person disregards the other components of what it means to be a person with dignity, a moral agent, a being that is more than a mechanism. Both dignity and agency will be addressed in later chapters, but the mechanistic or functionalist interpretation of the person and the good life will be highlighted and critiqued in this chapter. Aging, however, is clinically studied in fields beyond medicine; therefore, more than the functionalist interpretation must be addressed regarding the good life in aging so that the Third Age is not viewed as inherently bad.

Due to the interdisciplinary nature of studying the aging population, I will separate the relevant fields into three broad categories: historical approaches to aging well, healthy aging in

modern medicine, and medical ethics. In the first, historical part, works from thinkers, physician-philosophers, of the ancient era up to those of the Middle Ages will be reveal the way in which the practice of medicine addressed aging members of society primarily in practice. The second section of the historical overview will take up the development of gerontology as a social science, taking its cues from psychology, medicine, and sociology in the study of the aging population. Professional medical conceptions of aging well will constitute the second part of the chapter, taking up the question of what wellbeing means according to physicians and researchers. Following the review of medical literature, the third part will turn to the field of medical ethics in order to uncover the current ways in which the interdisciplinary insights on aging well have been received. These broad categories cannot possibly elaborate all of the intermediary steps in the given histories; however, the exemplary moments that follow are intended to provide a panoramic view of the beginnings, middle, and current state of the manner in which aging well has been and is conceptualized.

Historical Conceptions Of Aging Well

In the first part of this section, I will provide a brief history of aging in the field of medicine, starting with Hippocrates, moving swiftly up to the Medieval era, and ending with the 19th century. Important to note from the outset is that aging well in this and later sections will focus on the field of medicine or disciplines associated with medicine, and not those areas of inquiry that consider additional, more holistic conceptions of the good life. Some authors, particularly those writing before the modern era, do not distinguish between a philosophical conception of the good life and a healthy life. That being said, there may be redundancy in the authors, and perhaps some contradiction as the science of medicine has advanced over time; however, the

importance of the section below is to emphasize the fact that the question of healthy aging or aging well has been and continues to be a primary interest in medicine. The second part of this history will take up the developmental psychology foundations of gerontology and then move into modern gerontology's approach to the question of the good life.

Ancient Medicine

Known widely for the professional medical code of conduct, the Hippocratic Oath, 5th century BCE Greek physician (or philosopher-physician), Hippocrates is commonly referred to as the 'Father of Western Medicine.' Certainly, the title may be presumptuous given the more archaic and simultaneous development of medicine across myriad cultures; however, Hippocrates remains, at least in the West, a source of medical wisdom. Part of what has made him stand out amongst other ancient Greek, Egyptian, Indian, or Chinese physicians, was his ability to collect "what was known, tracing its resemblances and analyzing its differences, and so combining all into a rational method"¹ of medical literature. Aside from the widely known oath, Hippocrates and his followers² were *first* in outlining the relationship between health and disease

¹ Wilder, Alexander. *History of Medicine: A Brief Outline of Medical History and Sects of Physicians, from the Earliest Historic Period; with an Extended Account of the New Schools of the Healing Art in the Nineteenth Century, and Especially a History of American Eclectic Practice of Medicine, Never before Published.* (New Sharon, Maine: New England Eclectic Publ., 1901), 62.

² Wilder, *History of Medicine*, 64. A lack of concrete historical evidence has made it difficult to recall exactly what Hippocrates may have said or done. The Hippocratic tradition is a representation of his collected teachings fused with the work of his followers, those of the Hippocratic School of medicine. Teachings of the tradition are often attributed to 'Hippocrates,' where the name is symbolic of the leading member of the tradition. According to Wilder, an attempt was made to organize the tradition of Hippocrates into four distinct categories: 1) "Works distinctly Hippocratic, being in the Doric language, and 'manifestly authentic,' 2) Works of Hippocrates published by his sons and disciples, 3) Works written by others, accordant with his doctrines and ascribed to him, and 4) Works not in accord with his doctrines, but imputed to him"

vis-à-vis diet.³ Hippocrates saw medicine as a distinct discipline to be studied, illness as a natural occurrence, and prognosis and care as the paths to healing the person.

Hippocrates's working definition of health was informed by the philosophy of the time, namely the Doctrine of the Four Humors. The balance of the four humors, phlegm, blood, black and yellow bile, and a nondescript watery substance,⁴ yielded health, and an imbalance, disease or sickness. In "Airs, Waters, and Places", Hippocrates mentions the effects of phlegm and bile on the person such as, acute fevers attacking all but especially those with phlegmatic problems, and dermatological and ophthalmological problems resulting from biliary complications.⁵ In "Of the Epidemics," Hippocrates offers case analyses in which the impact of discolored or particularly acrid bile is prominent as an indicator of disease, and, over the progression of the disease, the return to the so-called normal coloration and odor as a sign of improvement and healing.⁶ Though each case was different, the Hippocratic tradition continued to focus on the nature of the disease by evaluating its effect on the balance of the humors, and the only definition of health to be generated was the aforementioned balancing of the humors.

Not surprisingly, the Hippocratic tradition does not offer a treatise on the aging person and what health might entail for the aging person outside of the humors. Still, what can be inferred is the association of the balance of functioning of the humors with the aging person's ability to live well. Specifically offered for the aging, however, are a series of aphorisms or brief

³ Hippocrates. *On Ancient Medicine*. Particularly Parts 3,5,6 <http://classics.mit.edu/Hippocrates/aphorisms.mb.txt>. Accessed October 16, 2015.

⁴ Some authors break down bile into black and yellow and do not address the so-called watery substance, while others do not separate bile and add the watery substance. The distinction is not of great importance for this particular work, but worth noting.

⁵ Hippocrates. *On Airs Waters and Places*. <http://classics.mit.edu/Hippocrates/airwatpl.html>

⁶ Hippocrates. *On the Epidemics*. Section 2, Case X.

statements that are unique to the aging or older/elder person. Missing from the writings is a definition of the aging person. Hippocrates does, however, mention younger and older patients, and goes into a fair amount of detail regarding how certain diseases effect older persons differently than younger persons.⁷ Be that as it may, some of what can be gleaned from Hippocrates is the way in which he conceptualized what aging entails. He addresses the notion of chronic disease, suggesting that once an aging person contract a chronic disease or condition, it is likely to never leave him or her for the aging have a depleted capacity to recover.⁸ Here is an early invocation of a popular modern claim regarding the aging: susceptible to disease and slow to recover. Not only does Hippocrates unknowingly set in motion a long history of generalizations made by medical professionals toward the aging, he also suggests the functional interpretation of the aging person. Stating that the aging person is likely to be diseased and incapable of ever fully recovering, the focal point becomes the bodily or mental function of the person rather than the whole person. Some of those conditions affecting the aging include: “pains of the joints, nephritis, vertigo, apoplexy, defluxions of the bowels, eyes, and nose, dimness of sight, cataract, and dullness of hearing.” These conditions are commonly associated with aging today and perhaps serve as the basis for the belief that aging is itself a disease to be cured. In fact, Hippocrates addresses the way in which the overweight person will naturally have a shorter life than the more fit person, suggesting that diet and exercise, as they are today, were ways in

⁷ There is one instance in which Hippocrates offers a chronological distinction. “Persons are most subject to apoplexy between the ages of forty and sixty.” Outside of this instance, there are few specifics regarding what age constitutes one who is old. Hippocrates. Aphorisms. Translated by Francis Adams <http://classics.mit.edu/Hippocrates/aphorisms.mb.txt>. Accessed July 28, 2015.

⁸ Hippocrates. Aphorisms. Translated by Francis Adams <http://classics.mit.edu/Hippocrates/aphorisms.mb.txt>. Accessed July 28, 2015.

which life could be extended and the chronic diseases of old age avoided.⁹ The healthy life is the young life, and the sick, diseased, or imbalanced life is most often the life of the older person; the good life is not and cannot be the aging life. For Hippocrates, life is simply more enjoyable when there are no physiologic abnormalities inhibiting the individual. Aging for Hippocrates is a physiologic abnormality.

Some five centuries later, Celsus Galen emerged in the Greco-Roman world, and would become the second most famous Greek physician after Hippocrates. Greek by birth and Roman by historical association, Galen is known as the founder of experimental physiology, a distinction that can be evidenced in today's medical textbooks.¹⁰ Galen, renowned for this practical skill and superior intelligence among physicians, offered what would become the standard of medical knowledge and care from the Greco-Roman world until the Middle Ages.¹¹ His encyclopedic collection provided the field of medicine with expanded, updated, and improved Hippocratic information, but more importantly he wrote more systematic and comprehensive works concerning areas of medicine and health unimaginable by Hippocrates and his followers. In the Hippocratic vein, Galen adopted the Four Humors, but added elements from Pythagoras and his own conception of the spirit, or *pneuma*.¹² Holmes explains Galen as representative of one school of so-called Old World medicine,

⁹ Hippocrates. Aphorisms. Translated by Francis Adams <http://classics.mit.edu/Hippocrates/aphorisms.mb.txt>. Accessed July 28, 2015.

¹⁰ Garrison, Fielding H. *An Introduction to the History of Medicine: With Medical Chronology, Suggestions for Study and Bibliographic Data*. 3rd Ed., Rev. and Enl. ed. (Philadelphia: Saunders, 1922), 103

¹¹ Wilder and Garrison agree that Galen served as the benchmark for medical practice and knowledge for some 14-17 centuries after his death. See Wilder, *History of Medicine*, 101 and 103-110.

¹² Garrison, *An Introduction to the History of Medicine*, 103. The notion of a spiritual dimension to healing will be taken up in chapter 3 more explicitly.

the body, the microcosm like the macrocosm, was made up of the four elements – fire, air, water, earth; having respectively the qualities hot, dry, moist, cold. The body was to be preserved in health by keeping each of these qualities in its natural proportion...diseases which arose from excess of heat were to be attacked by cooling remedies (etc.).¹³

He offered further remarks on elements of the Hippocratic tradition in a number of his writings, but what is most relevant in the transition from Hippocrates to Galen regarding health and the aging can be found in at least two of the seven classes of some 700 books,¹⁴ Hygiene and Therapeutics.

The collection of works in the class of hygiene demonstrates the ways in which food and air contribute to the preservation or depletion of health, and the class of therapeutics emphasizes the curing of disease, most of which is in accord with methods outlined by Hippocrates. Health, explains Galen, is judged by all of an individual's natural functions, and is defined as a state consisting in the full functioning, free from pain or uneasiness, of all an individual's faculties.¹⁵ *Normal* function, then, is the meaning of health. As was seen in the works of Hippocrates, exercise and diet are the primary means by which good health is attained, restored, and preserved. Interestingly, Galen notes that health, though contingent upon the physical and mental functioning, may not provide a complete picture of the good life:

Health, action, and beauty, in conjunction, form the summum bonum of the body; and what tends to this conjunction is by him [Galen] traced in the particulars of the air, wakefulness

¹³ Holmes, Oliver Wendell. *Medical Essays, 1842-1882*. (Boston: Houghton, Mifflin, 1883), 318

¹⁴ Hippocrates. *The Writings of Hippocrates and Galen. Epitomised from the original Latin translations*, John Redman Coxe (Philadelphia: Lindsay and Blakiston, 1846), 473-477. Coxe uses the existent organization of Galen's texts and qualifies them for the reader. Those seven classes are: Physiology, Hygiene, Aëtiological (study of disease), Semeiotics (study of disease re: prognosis), Pharmacy, Phlebotomy (study of blood re: bloodletting), and Therapeutics.

¹⁵ Coxe, *The Writings of Hippocrates and Galen*, 571-572.

and rest, sleep, motion, food, and drink; and the influence of moderation in preserving unchanged a state of health, is noticed.¹⁶

The summum bonum, or highest good, is invoked to signal Galen's appeal to philosophical notions of the good life; however, it is comprised of bodily imagery. At first glance Galen appears to depart from Hippocrates, but it is clear that Galen does not dissociate health or the normal body from the good life. In fact, use of the word beauty, a subject to be explored in the next chapter, proves to have further damaging effects on how the good life in aging is conceptualized regarding the specious link between aesthetics and functionality. Still, Galen contributed positively insofar as he went beyond Hippocrates in speaking to the summum bonum. He built a bridge between medicine, philosophy, and theology, a foundation upon which later inquiries into medicine, and the intersections of medicine, theology, and philosophy would be based.

Offering one succinct explanation of medicine in the Medieval period is near impossible given the expanse of time, the overlapping developments across the European Continent, and the inescapable influence of the Catholic Church on Europe after the collapse of the Roman Empire and through the Renaissance. The impact of religion on medicine in the Dark and Middle Ages can be traced back to the conversion of the Saxons, the monastic movement's belief in healing as a divine calling, the introduction of Arabic-Muslim medicine to the somewhat-established practice of European medicine, Jewish medical care for the clergy, and the relationship between the practice of medicine and clergy made manifest in the medical School of Salerno.¹⁷

¹⁶ Coxe, *The Writings of Hippocrates and Galen*, 575.

¹⁷ Garrison, *An Introduction to the History of Medicine*, 126-137.

As the healing practice of the middle Ages gave way to further advancement, it remained fundamentally homeopathic, and health continued to be defined in philosophical or religious terms. A popular response to homeopathic medicine was provided by American physician Oliver Wendell Holmes. With the emergence of new pathologies in Northern Europe and later the Americas, Holmes sets out to debunk the popularity of health as it had been conceived by the so-called herb-doctors or homeopaths. Instead, he urged that medicine re-conceptualize the meaning of health and how medicine, as a scientific discipline, ought to respond to the needs of patients. Holmes' language of disease and health showed a marked change in the practice of medicine and in medical knowledge in general. "Every healthy cell," he wrote "necessarily performs its function properly so long as it is supplied with its proper material and stimuli." Here is a conception of health that is not contingent upon the elements or of philosophical, cultic, or astrological beliefs; instead, this understanding of health is a precursor to what one may read in today's biology textbooks. For Holmes, food was an important element of health, but not a panacea. Other elements,¹⁸ which during his time were not considered medicinal, were to be used to restore the cells of the body to order, to kill parasites, and to heal wounds. According to Hippocrates and Galen, an individual's health was the result of some sort of balance, and Holmes, standing on the shoulders of others, identified the cause of that imbalance on a fairly advanced level given the technology of his time. Starting in the 19th century and continuing through today, health is understood to be proper cellular function in accordance with the design of the human body, while its counterpart, disease, is any disordered functioning on the cellular level. Though celebrating the progress made by Holmes regarding the cellular dimension of

¹⁸ Holmes, *Medical Essays*, 254 "Iron, phosphate of lime, sulfur" are examples of substances he wishes to be included in medical practice. His argument is based on their efficacy for plant cells, and expanding the definition of what should constitute 'food' for the human."

health is important, the literal microscopic turn is symbolic of the way in which the good life in aging would continue to be described in medicine. In Hippocrates and Galen, aging came with disease and severely impeded one's living well. Emphasis on the functioning of the body presented a one-dimensional view of what it means to live the good life, and, regarding the aging, how the aging may have been viewed within society (a point to be taken up in chapter two). In turning to the cellular level, the person is likely to be overlooked, if not dismissed, as person in favor of an examination of the healthy or diseased cells. Examining the cellular health of the aging person not only reduces his or her good life to bodily functioning, but also goes further in truly reducing the aging person the smallest mechanisms of which the body is composed, cells.

Life Stages And The Emergence of Gerontology

As a field of study, gerontology is the result of combined efforts from the social sciences. Despite the influence and importance of economics, political science, and anthropology, gerontology champions one social science over the others, namely psychology. In a majority of gerontological writings the works of Sigmund Freud, Carl Jung and/or Erik Erikson are referenced as foundational influences, or sometimes more directly connected as nascent forms of modern gerontology. Because of the importance placed on these transformative psychologists, I will examine the one whose work is most closely connected with what would become gerontology, namely Erik Erikson's developmental psychology.¹⁹ After a short review of Erikson, I will turn to modern gerontological conceptions of aging well.

¹⁹ The choice of Erikson is not arbitrary insofar as he represents a thinker who synthesized Freudian psychoanalysis into his developmental approach. Carl Jung's influence in gerontology will be addressed through the voice of his followers in a later chapter.

Erik Erikson

Concerned with the experiential and behavioral changes experienced at various ages, developmental psychology has its roots in evolutionary science, philosophy, and turn-of-the-20th-century psychology.²⁰ Historically, developmental psychology has focused on childhood, as was the case with Freud, but as the 20th century unfolded, its emphasis shifted to adolescence, adulthood, and eventually a complete lifespan development approach and life course approach.²¹ Integral to the shift from childhood to adulthood, and from Freud to a newer type of psychoanalysis was Erik Erikson. Erikson admits²² to knowing a much older and ‘different’ Freud than the one who created the field of psychoanalysis; he claimed to be indebted to Freud’s analysis of the psychosexual/psychosocial development that took place within childhood and that served as the basis for his developmental stages. What distinguishes Erikson from Freud and other developmental psychologists was the way in which he approached adulthood, in particular his identification of three distinct yet interconnected stages: young adulthood, maturity, and old age. The stages will be addressed below, but suffice it to say that such an approach “opens [our] awareness to the full developmental potentials of all stages of life –that is, both the later stages

²⁰ Butterworth, George. *Principles of developmental psychology: An introduction*. (Hoboken: Taylor and Francis, 2014), 3-14

²¹ Butterworth, *Principles of Developmental Psychology*, 244-246 According to Butterworth and Harris, the lifespan approach has contributed greatly to the study of aging for it has been able to address the myriad ways in which an individual’s circumstances (physical health, culture, time period, social class) affect the way in which one ages. The life course approach, in contrast, emphasizes the impact of particular life events on the aging person. That impact often correlates to a change, perhaps radical, in behavior that sets the individual off in a new direction. The contexts of these events are often characterized as family, work, health, and marriage.

²² Erikson, Erik H., and Robert Coles. “The First Psychoanalyst (From *Insight and Responsibility*)” in *The Erik Erikson Reader*. 1st ed. (New York: W.W. Norton, 2000), 139.

when disturbances often become fully manifest, and the earlier ones, to which they are clearly related.”²³

How Erikson influenced gerontology requires an examination of his major project, the Psychosocial Theory of Development. His theory of development highlights a psychosocial conflict believed to invariably arise as a person moves from one developmental stage to the next. Progressing through the stages “requires the integration of personal needs with the demands of society,”²⁴ a task that is complicated by the social and cultural forces to be addressed in chapter two. Erikson’s chart²⁵ of psychosocial crises outlines eight stages of development, but conspicuously leaves out a number or range of numbers representing the ages for a given phase.²⁶ Without the chronological constraint, Erikson’s work provides a necessary flexibility and fluidity for study and analysis, an analogue to the heterogeneity of the aging population. It

²³ Erikson, Erik H. *Adulthood: Essays*. 1st ed. (New York: Norton., 1978), 23.

²⁴ Schroots, Johannes. J. F. 1996. “Theoretical developments in the psychology of aging,” *The Gerontologist* 36 (6): 742-8, 744.

²⁵

<i>Developmental Stage</i>	<i>Conflict</i>	<i>Strength/Virtue</i>
Maturity/Old Age (8)	Ego Identity vs. Despair	Wisdom
Adulthood (7)	Generativity vs. Stagnation	Care
Young Adulthood (6)	Intimacy vs. Isolation	Love
Adolescence (5)	Identity vs. Role Confusion	Fidelity
School Age (4)	Industry vs. Inferiority	Competence
Play Age (3)	Initiative vs. Guilt	Purpose
Early Childhood (2)	Autonomy vs. Shame and Doubt	Will
Infancy (1)	Basic Trust vs. Mistrust	Hope

²⁶ Erikson, Erik H., and Joan M. Erikson. *The Life Cycle Completed*. Extend version ed. (New York: W.W. Norton, 1997), 105. While the original edition of the text does not assign age ranges to phases, the final (Ninth) stage penned by Joan Erikson does in fact offer some chronological context. “Old age in one’s eighties and nineties brings with it new demands, reevaluations, and daily difficulties. These concerns can only be adequately discussed, and confronted, by designating a new ninth stage to clarify the challenges. We must now see and understand the final life-cycle stages through late eighty- and ninety-year-old eyes.”

enables the stages of development and the corresponding characteristics/conflicts to be examined more openly. Thus, Erikson's developmental approach offers a sufficiently wide range of interpretation for the diverse aging population. For now, I will focus on Stages Seven and Eight as they were understood prior to their adoption by gerontology.

Each stage points to a particular psychosocial conflict expressed with two terms, each characterizing the ego struggle of a given developmental phase. One term represents the syntonic, or helpful, characteristic necessary to 'get through' the particular stage; the other is the dystonic tendency, or the one that impedes developmental progress. For example, in infancy the antithetical tendencies are basic trust and basic mistrust, and upon moving into the next stage the individual has developed the strength of hope. The syntonic is thought to be dominant insofar as a greater presence of that trait will move one closer to resolving the crisis of that stage, but that is not to say that the dystonic trait is vanquished once the stage is completed. The strength that emerges from the completion of a given stage goes on to re-contextualize the landscape of one's development in two ways. First, development is an ongoing process that is more fluid than not. One can advance through stages but revisit parts of a given psychosocial struggle at any given time during one's life, thus employing the strength of that stage already achieved in combination with the experience and other relevant strengths achieved through development. Second, each strength achieved as one passes through a stage of development is needed for the successful completion of the next stage.

Through the passage of each stage, the strengths achieved offer a new lens for evaluating and employing previously developed strengths as one progresses through the life stages.²⁷ The

²⁷ Erikson, *The Life Cycle Completed*, 59. "But the chart also makes clear in its verticals that each step (even wisdom) is grounded in all the previous ones; while in each horizontal, the developmental maturation (and

person who is in Old Age (according to Erikson's framework), may reenter the generative stage that precedes Old Age, Adulthood. Doing so means having to work to once again to resolve the interplay between generativity and stagnation in light of his or her new struggle: integrity and despair, and strength: wisdom. Thus, we turn to Adulthood before the more immediately relevant developmental stage.

Adulthood,²⁸ Stage 7, possesses the tendencies of Generativity and Stagnation.

Generativity encompasses "procreativity, productivity, and creativity, and thus the generation of new beings as well as of new products and new ideas, including a kind of self-generation concerned with further identity development."²⁹ The antithetical tendency, stagnation, can be experienced by any person, but is particularly relevant to the aging person who transitions from being vitally necessary to the workplace or the family (and in effect one's society) to being perceived as inessential. Feeling as though one is unproductive or lacking in value can be debilitating, thus the psychosocial struggle that occurs in one's later years. Adulthood can be interpreted as the "generational link"³⁰ because the resolution of generativity and stagnation gives the aging person a strength that comes with a sense of meaning and purpose, namely care. The adult who is concerned with being productive is so concerned because he or she has an interest in the development of the future, whether that is in the form of children, products (things the agent creates), or ideas. Thus, caring is not only caring about, but also caring for or taking

psychosocial crisis) of one of these virtues gives new connotations to all the 'lower' and already developed stages as well as to the higher and still developing ones."

²⁸ Erikson deviates from the rigidity of his chart and classifies both young and adulthood and adulthood under the larger phase, Adulthood.

²⁹ Erikson, *The Life Cycle Completed*, 67.

³⁰ Erikson, *The Life Cycle Completed*, 66.

care of those things for which the individual is responsible.³¹ Part of this process involves setting the appropriate models of behavior and activity that the adult wishes the next generation to continue, i.e. what it means to be a parent.³²

Although the outcome of Stage 7 is positive, an overemphasis on one's productivity can have detrimental effects in a social environment such as the US. In the seventh stage of development, the positive experience of aging is achieved when the individual learns how to provide something, i.e. care or knowledge, to others. The very value that the aging person believes him or herself to have lost in retirement must be retrieved through the discovery of a new productive contribution to the family or society. The cultural influence on self-worth regarding productivity will be explored more thoroughly in the next chapter, but its presence in Erikson's stages is noteworthy given his own internalizing the relationship between production/contribution and self-worth. Instead of focusing on the biological functioning of the aging person as medical authors do, Erikson implicitly suggests that the development directed toward the good life is in part functionalist. The meaning of functionalist, however, shifts from the biological or cellular functioning of the aging person to the role that he or she plays in the family or in society. Despite the damaging potential of Erikson's tacit functionalism, finding a new role to fill is a necessary step. The ability to adapt and find a new role makes possible any and all success that is to be had in the eighth stage.

Old Age, Stage 8, is characterized by the struggle between Integrity and Despair and Disgust; the outcome of which is Wisdom. In the analysis of this last stage³³ Erikson returns to

³¹ Erikson, *The Life Cycle Completed*, 67.

³² The intergenerational concern demonstrated by adults during this developmental phase will be explored in more depth in a later chapter.

the very first strength achieved in the stages of development, hope. By the time an individual has reached Old Age, he or she has a mature and profound hope that has been shaped and informed by the experiences of all previous stages of development. The hope of Old Age is described as capable of overcoming the despair one feels when confronted with mortality. The positive tendency, integrity, enables the individual to synthesize all of one's previous experiences, assuming, of course, that the individual has the cognitive health enabling this type of review. Without the requisite mental health, it would be impossible to mature. Surely, the timing of the final stage³⁴ and inherent difficulty with confronting mortality and properly reviewing one's life, would make mental health all the more important for Stage 8. Also assumed is an autonomous aging person, who has been and remains capable of negotiating developmental stages without the assistance of others. Erikson does not attend to the presence of, let alone assistance of others in the individual's progress through the developmental stages. Autonomy and dependence will be addressed in chapters two and four respectively, but Erikson, like his internalization of the productivity-value relationship above, adopts a cultural perspective that does not adequately represent the human experience. He ignores the aging person's experience regarding human sociality. Erikson presumes too much about the kind or level of autonomy experienced by all persons, and that psychosocial development can be completed so long as the individual matures in accordance with his schema. The irony is that the social dimension of Erikson's approach appears to be more about isolated social encounters rather than the ways in which relationships can shape, inform, and facilitate the good life.

³³ Erik Erikson's chart ends with this stage, and there is no official place for Stage 9 created by Joan Erikson.

³⁴ I do not mean to fall into the trap of suggesting that all aging people will suffer from some cognitive impairment. However, as one ages, there is a greater risk for a decline, to varying degrees, in cognitive function.

These two glaring oversights notwithstanding, Erikson explains the tendency to conduct a form of life review, to create a more cohesive and whole vision of one's life is a syntonic developmental shift for it provides a type of closure for the person who is confronted by mortality.³⁵ Realized upon the reconciliation of despair and integrity, is Wisdom. Wisdom "rests in the capacity to see, look, and remember, as well as to listen, hear, and remember."³⁶ It is in the actualization of wisdom that we come to see a nascent form of Lars Tornstam's theory of gerotranscendence³⁷ and what might be the Ninth Stage. Having achieved wisdom in the Eighth stage, the individual realizes the capacity to move beyond the previous stages by continuing to develop in a somewhat-unconventional manner, meaning non-linear or non-formulaic. The gerotranscendent individual having moved into Joan Erikson's Ninth Stage, continues to develop outside of traditional notions of self and social norms, regaining so-called "lost skills, including play, activity, joy, and song" and even "a major leap above and beyond the fear of death."³⁸ Part of this rather fluid stage is the capacity for "feedback on a life that can be relived in retrospect,"³⁹ which presents its own final tension between the syntonic and dystonic: to be able to move forward with the purpose without being weighed down by the past, but instead being informed by it. The conciliatory review that takes place during this last stage of development will feature

³⁵ Erikson, *The Life Cycle Completed*, 63.

³⁶ Erikson, *The Life Cycle Completed*, 112.

³⁷ In the 9th Stage, Joan Erikson focuses on the dystonic tendency of each developmental phase. She does this so as to highlight the potency of the dystonic elements when there no longer exists the capacity to wage the developmental battle. Essentially she poses the practical question: what happens when one can no longer see, listen, hear, or remember? As mentioned above, this stage does come with an age range, eighties and nineties; however, seeing as it describes a particular set of limited capacities, one could appeal to the potency of the dystonic tendency once its corresponding physical or mental capacity has diminished.

³⁸ Erikson, *The Life Cycle Completed*, 127.

³⁹ Erikson, *The Life Cycle Completed* 128.

prominently in the theological approaches to aging well addressed in chapter three, but it is worth noting here that this psychological contribution to aging well crosses over into other disciplines.

However, the reading of gerontology into his developmental framework is retrospective, and not necessarily the point of Erikson's project. What remains then is how the connection was made between psychoanalytical work and the unintentional influence on gerontology. That connection comes in snippets in Erikson's other writings that point to 'real life' examples of his developmental schema. One such text is "Reflections on Dr. Borg's Life Cycle."

Erikson admits that the protagonist of Ingmar Bergman's film *Wild Strawberries*, Dr. Isak Borg, is a favorite in his course on the life cycle. The story offers a reflection that highlights the complexities one faces whilst vacillating among the stages of adulthood. Relying on the explanation of Old Age, Erikson notes that Dr. Borg hopes to understand his development, "in light of the whole course of life."⁴⁰ Though Dr. Borg has become aware that his age has brought him face-to-face with death, his struggle revolves more around affirming his legacy or life's accomplishments. "Borg's old-age struggle against despair that makes him comprehend what he has become must not be all that he is and must not be all that he leaves behind;"⁴¹ this is struggle typifies Stage 8. In Old Age, the psychosocial struggle causes the older person to reflect backward and forward across one's life and future in an attempt to stitch together known meaning in the face of the unknown. Erikson captures this struggle in addressing a scene in which Borg laments he is no longer necessary or depended upon by others. Continuing to reflect,

⁴⁰ Erikson, *Adulthood*, 5.

⁴¹ Erikson, *Adulthood*, 7.

Dr. Borg offers rather morose comments on his dreams, wondering if they are harbingers of death. The pause and reflection offered by Borg captures precisely what Erikson believes the Life Cycle does, namely help an older adult “gain some integrated sense of one’s life.”⁴² The conclusion of Erikson’s brief synopsis is that when the aging person is confronted with the *final* stage of the life cycle, he or she returns to the beginning, to the fundamental hope of infancy with a completely new way of understanding and interpreting the developmental battles one had previously thought to be resolved.

In the conclusion of the analysis, Erikson provides the answer to the question of the link to gerontology: Wisdom, “is the *detached and yet active concern with life itself in the face of death, and that it maintains and conveys integrity of experience in spite of the Disdain over human failings and the Dread of ultimate non-being.*”⁴³ Fulfilling the life cycle is a matter of constantly engaging with it for the benefit of the self and future generations. Erikson concludes that the generational cycle—one group’s interacting with another, or specifically the members of later adulthood passing the proverbial baton to the next group—is “vital to the maintenance of evolving social structures.”⁴⁴ Regarding the service of future generations, the purpose of fulfilling the life cycle can be interpreted differently. What appears to be a framework intended to help the individual navigate various psychosocial crises so that he or she may be at peace throughout the developmental process actually takes on a bit of a different meaning at the end. No longer is the individual solely responsible to and for him or herself, an already problematic

⁴² Erikson, *Adulthood*, 13.

⁴³ Erikson, *Adulthood*, 26. Emphasis in original text.

⁴⁴ Erikson, *Adulthood*, 29.

point to be debated in later chapters; instead, the aging person who has made it to Old Age is obliged to be productive by way of passing on one's knowledge to and caring (in various capacities) for younger generations. The turn outward, though described in a way that almost reads as a boon to the aging person, is yet another way in which the good experience of aging and arguably the good life in aging is located in one's productivity. Unfortunately, the implicit connections of Erikson are lifted up and concretized in more robust and overtly production-oriented gerontological approaches to aging well.

John Rowe And Robert Kahn

Aging well in gerontology experienced a renaissance in the 1980s that began with John W. Rowe and Robert L. Kahn's publication of a short article, "Human Aging: Usual and Successful."⁴⁵ Moving away from a developmental approach, the authors focus on how to age well rather than on the differences between the stages of life. This new conceptualization of aging was intended to "counteract the longstanding tendency of gerontology to emphasize only the distinction between the pathologic and nonpathologic,"⁴⁶ or to debunk the first myth of aging that "to be old is to be sick."⁴⁷ The short article grew into a larger benchmark text that addresses three foundational questions: "what does it mean to age successfully, what can each of us do to be successful at this most important life task, and, what changes in American society will enable

⁴⁵ Rowe, John W., and Robert L. Kahn. "Human Aging: Usual and Successful." *Science* 237, no. 4811 (1987): 143-49.

⁴⁶ Rowe, John W. and Robert L. Kahn. "Successful Aging." *The Gerontologist* 37, no. 4 (1997): 433-40, 433. The term pathologic is used here to preserve the integrity of the quotation, but pathologic has been replaced by pathogenic elsewhere in the this chapter and the dissertation.

⁴⁷ Rowe, John W., and Robert L. Kahn. *Successful Aging*. (New York: Pantheon Books, 1998), 13.

more men and women to age successfully?”⁴⁸ This turn to the ‘positive aspects’ of aging replace Erikson as the foundation for further gerontological scholarship.⁴⁹ While a more in depth look into the text will be taken below, a brief summation of what the authors mean by successful aging will suffice at present.

Successful aging is defined by three central behaviors or characteristics: low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life.⁵⁰ First, low probability of disease encompasses the “absence, presence, or severity of risk factors for disease.”⁵¹ Thus, it becomes relevant to investigate not only the intrinsic factors that play a part in the contraction of disease during the aging process, but also the extrinsic factors that lead to lifestyles that possess a disproportionate proclivity for disease.⁵² The conclusion of such an investigation reveals that not all aging people fall ill with the same diseases or disabilities. Moreover, those who fall ill do not universally experience the de facto suffering of old age so much as the culmination of preventable conditions, suggesting that the link between old age and inevitable disease is tenuous at best. What Rowe and Kahn have done in turning first to health as a determinant of successful aging is unfairly limited to a gerontological notion of aging well. Universalizing the aging experience comes with a series of problems, the least of which is the actual condition of health experienced by all members. They

⁴⁸ Rowe and Kahn, *Successful Aging*, xi.

⁴⁹ While the successful aging model has proved important, it will be explored later an approach that finds its roots in American cultural and social influences that muddy the waters for what it might mean to age well.

⁵⁰ Rowe and Kahn, “Successful Aging,” 433.

⁵¹ Rowe and Kahn, “Successful Aging,” 433.

⁵² This further supports Rowe and Kahn’s basic premise that the aging population is not homogenous. However, I shall argue that while it is true that the aging population is not homogenous in terms of disease or ability to function, there can exist a framework for aging well that is applicable across the heterogeneous aging population.

do not account for the gendered experience of aging, the economic dimensions of health care, or the very basic possibility that one can be sick and still live a good life. Worse, however, is the manner in which Rowe and Kahn address disabilities as impediments to successful aging.

Disabilities will be covered extensively in the fourth chapter, but it is worth noting here that the suggestion that being disabled precludes the aging person from living the good life is abhorrent. Equally objectionable is the idea that aging is a condition likened to a disability. To be clear, the authors do not make the claim that aging is a disability, but the manner in which they speak of aging and disability leaves too much space for such an interpretation to be made.

In addition to the element of disease, they argue that a capacity for high cognitive and physical function is essential to successful aging. Like Erikson before them, Rowe and Kahn fall victim to the cultural perceptions of their time, and perpetuate the belief that the experience of aging is riddled with loss of ability to function. However, loss of physical or cognitive function can be avoided or prevented, and losses can be restored.⁵³ Yet, what this element shows is the repeated pattern of focus on functionality as essential to aging well, which in this case is described as successful aging. The importance of health and functioning cannot be understated in one's pursuit of the good life in aging; without health or an adequate level of function, aging well may be exceptionally difficult, but overstating the importance of functionality runs the risk of reducing the aging person to a functioning machine rather than a less than optimally healthy human being. The authors conclude that most undesirable cognitive and physical effects of aging do not come until very late in life and more often than not do not drastically impede an aging person's overall functioning. Despite this 'late onset' caveat, successful aging is described as impossible without a capacity for high cognitive and physical functioning. Once the authors

⁵³ Rowe and Kahn, *Successful Aging*, 42.

provide actual parameters that qualify high levels of functioning, it will likely be the case that too many aging people will be excluded from aging well at one point in their lives or another.

Lastly, the third behavior or characteristic, active engagement with life, reminds the aging person that involvement with others in varied ways continues to be important. Rowe and Kahn explain that isolation or lack of social relationship pose a risk to one's health. Social interactions, impromptu or organized, can have positive health-relevant effects (i.e. scheduled encounters can keep a declining mind active, meetings themselves can be centered around physical activity aimed at promoting health etc.). Rowe and Kahn stress that no single type of support is uniformly effective, thus reinforcing the import of thinking about the heterogeneity of the aging population rather than its uniformity.⁵⁴ Without properly naming it, the authors identify the agency of the aging person as a desired end of successful aging. The three elements of successful aging addressed demonstrate that agency is both the means to and the end of successful aging. One's ability to act upon and interact with others, and to be aware of one's self and one's acting are necessary for and revelatory of successful aging. The agent who successfully ages is one who is physically well and mentally sound, and capable of making use of his or her agency to remain an active member of society. Chapters three and four will explore agency in more depth, but this particular contribution of Rowe and Kahn to the discourse on aging well within gerontology is critical. Turning to agency is a positive step because it allows for a broadening of the definition of how diseased or how highly functioning an aging person might be. Agency relaxes the criteria of aging well that appear to be more limiting than aging persons might wish. As a basic understanding of agency, the capacity for acting and being acted upon sufficiently expands the scope of who can actually age well and by what standards an

⁵⁴ Rowe and Kahn, "Successful Aging," 438.

individual's good life in aging can be measured (if such a thing is possible). As will be shown in Chapter Two, Rowe and Kahn's open-ended description of social engagement or activity is also important because being active in society does not or should not have to require economic productivity. Raising up their interpretation of an active lifestyle in aging is important. Yet, because of the remarks about functionality, the cultural environment draws its own conclusion about successful aging in such a way that functionality is attached to productivity: if one is functional, he or she should be productive/contributing to society; if one is not productive/contributing to society, it must be because he or she is not functional. Despite its faults, Rowe and Kahn's model of successful aging can help inform ethics of aging that seeks to negotiate agency, activity, and health in pursuit of the good life in aging.

Lars Tornstam

Another approach born during the gerontology renaissance of the 1980s was Lars Tornstam's model of gerotranscendence. Gerotranscendence represents both fulfilling and moving beyond Erikson's final developmental stage. In effect, it is a theory that addresses the totality of aging in that it is not limited to those members of the Third and Fourth Ages; rather it is a framework that is applicable to all starting in young adulthood.⁵⁵ Tornstam notes that, according to Erikson, those who do not reach the eighth and final stage ultimately experience despair and fear of death. That despair, according to Tornstam, can only be overcome by embracing a model of gerotranscendence.⁵⁶ What then is gerotranscendence?

⁵⁵ Tornstam, Lars. *Gerotranscendence: A developmental theory of positive aging*. (New York: Springer Publishing Company, 2005), 39.

⁵⁶ Tornstam, *Gerotranscendence*, 40.

Tornstam's model brings together his complex view that "old age is not a mere continuation of the activity patterns and values of mid-life, but, rather, something different: a transformation characterized by new ways of understanding life, 'activities,' oneself and others."⁵⁷ Divided into three levels of age-related ontological change,⁵⁸ gerotranscendence addresses the shift humans make, or should make, from a materialistic and rational perspective to a cosmic and transcendent one. The first level of change is the cosmic dimension in which broad existential changes occur. Time is an integral area of change in this first level insofar as the ways in which time is understood shifts so as to break down the barriers that exist between living in the present and being able to make previous times equally present. An increased connection to earlier generations emerges that not only serves the function of remembering, but also helps the gerotranscendent individual recognize his or her importance as someone who represents a living connection between generations. In many ways, this is not all that different from the recognition of one's relationship to future generations that appears in Erikson, Rowe and Kahn, and will appear in the theological literature of the third chapter. It is markedly different in that it does not oblige an aging individual to make him or herself of service to the younger generation in some capacity. In some cases, Tornstam notes that recognizing one's connectedness to both previous and future generations inspires a popular thought that one has lived long enough and served his or her purpose. Second, aging the concern individuals have for themselves change "in the view of the present self and the self in retrospect."⁵⁹ Tornstam begins addressing the changes within

⁵⁷ Jewell, Albert J. 2014. "Tornstam's notion of gerotranscendence: Re-examining and questioning the theory." *Journal of Aging Studies* 30:112-120, 112.

⁵⁸ Schroots, "Theoretical Development in the Psychology of Aging." 746.

⁵⁹ Tornstam, Lars. "Maturing into Gerotranscendence," *Journal of Transpersonal Psychology* 43 (2): 166-80 (2011), 1.

the self as self-confrontation, paying homage to Carl Jung, but what is perhaps more important and most relevant, is what he refers to as a “decrease in self-centeredness.”⁶⁰ Tornstam argues that this move provides relief to those whose aspirations were unrealistic and damaged their self-esteem. Decreasing self-centeredness reduces the so-called burden of thinking that one is the center of the universe, which more often than not is psychologically damaging. Turning away from self-centeredness is a theological task picked up on by Edward Vacek in his articulation of the virtues and vices of retirement, but it is Tornstam who distinguishes himself within gerontology for highlighting the importance of this move so as to facilitate completing the life cycle. Detaching oneself from the type of self-interest that can impede one’s happiness is integral to aging well, and will be more fully addressed in the next chapter. A gerotranscendent individual’s ability to break from patterns of self-centeredness and reflect upon the good (and bad) that one has achieved for oneself and others better enables him or her to truly understand life in the past, present, and future, differently. Last, social and personal relationships begin to more closely mirror the final developmental change of the gerotranscendent person. Tornstam notes that the gerotranscendent person begins to lose interest in superficial relationships, and in an attempt to demythologize the risks of isolation, sometimes opts for solitude because it can be more meaningful. This is not to say that Tornstam believes that living in solitude is the best approach to or a necessary step for aging well; however, he is clear that being alone in some capacity is integral to the satisfaction of gerotranscendence. Thus, he navigates a very fine line between an overemphasis on autonomy in aging and the myth of complete dependence. He leaves open the possibility of experiencing the good life in aging in isolation and in relationship, without claiming them to be mutually exclusive or placing restrictions on one’s commitment to a

⁶⁰ Tornstam, “Maturing into Gerotranscendence,” 171.

particular mode of aging (i.e. autonomously or completely dependently). Tornstam's insights regarding autonomy and dependence are integral to an ethics of aging, and will be further explored in later chapters.

Margaret Cruikshank

The imperfect work of Rowe and Kahn and other gerontologists continues to influence how gerontologists think about, address, and engage with the aging population. A problem with their work is that successful aging is contingent upon individual effort. Margaret Cruikshank argues that “the success model overlooks the elements of luck and mystery in aging.”⁶¹ Aging, she argues, is socially constructed insofar as the abilities of the individual to live well are constrained or at least influenced by other forces. This particular issue will be considered in economic and political contexts in the following chapter; however, Cruikshank's emphasis on the ways in which a feminist approach to gerontology will contribute to the flourishing of aging women, or as she terms it “comfortable aging”⁶² is relevant to this chapter's discussion.

In crafting a model of comfortable aging, Cruikshank appeals to the oft-overlooked experience of the aging woman. She notes that the experiences of women are fundamentally different than that of men, and this oversight is intensified when it comes to the aging woman. Physical health and its impact on aging well is but one area in which women experience a disproportionate amount of discomfort compared to their male counterparts. Despite the fact that women live longer than men, they are 50% more likely to have arthritis, and deal with more

⁶¹ Cruikshank, Margaret. *Learning to be Old: Gender, Culture, and Aging*. 2nd ed. (Lanham, Md.: Rowman & Littlefield Pub., 2009), 3.

⁶² Cruikshank, *Learning to be Old*, ix.

chronic illness such as hypertension and diverticulitis.⁶³ Women are left to “see their health status only in individual terms and expected to find solutions on their own,”⁶⁴ rather than be given the same kind of social, economic, and medical support that their male counterparts are given. Nutrition is one of the areas of healthy aging that affects women differently. After menopause maintaining weight becomes more difficult as lifestyles change without a correlative change in diet and amount of exercise, and because women live longer than men but have earned lower wages, some of the means necessary to improve physical health are lacking.⁶⁵ This problem is highlighted by research that shows “people over 65 spend an average of 20% of their annual income on health care gaps in Medicare coverage,” with the “costs of single, older women” nearing one third of an individual’s annual income.⁶⁶ Diagnosis has been shown to differ between men and women, at least on the subject of heart disease and heart attack. In women, presentation of the condition may be atypical—back instead of chest pain, no arm pain. After heart attacks and diagnosis of heart disease, studies have shown that women are less likely to receive a pacemaker in an expedient manner. Mental health, particularly the question of depression, represents another area in which the healthy aging of a woman is different than men. Cruikshank connects the effect of prescription medication designed for younger persons on the aging woman with changing the very structure and chemistry of the brain. In the case of women whom report depression more often than men throughout their lives, the experiences of loss of partners, illness, and loss of independence, represent a confluence of issues that exacerbate an

⁶³ Cruikshank, *Learning to be Old*, 105.

⁶⁴ Cruikshank, *Learning to be Old*, 70.

⁶⁵ Cruikshank, *Learning to be Old*, 73. This topic will be explored in more depth in Chapter Two.

⁶⁶ Cruikshank, *Learning to be Old*, 108.

underlying pathology which leads to further isolation, inactivity, and an increased likelihood for more severe forms of depression.⁶⁷ In short, aging women tend to suffer more and worse than men, yet are given fewer resources, thus thwarting their ability to age well according to the medical and gerontological models.

Moreover, women tend to have the experience of being a caretaker or caregiver as they age, a specialized and demanding type of service that further complicates the aging process. Increased longevity and shifting demographics have resulted in a change in the ways in which care is given to older persons. Caregiving, a task that disproportionately is expected of women, is understood as anything from intermittent help for a family member to round-the-clock care given to a family member in one's home.⁶⁸ Perhaps this is a result of a cultural expectation that women be caregivers, a sexist tendency that piggybacks Erikson's and Rowe and Kahn's thought that the aging person should be doing something for others. As a result, women are forced to make sacrifices in other areas of their lives, i.e. career. Loss of work has its own consequences that manifest in the moments of caregiving, i.e. lost wages, but also later on when that very caregiver is in need of care and does not have the income or savings to take care of oneself, thus creating a cycle of family-based and women-centered care. The very experience of taking on the role of caregiver drastically changes the ways in which one might come to age well, or comfortably. Perhaps it is the cycle of caregiving that perpetuates the myths about dependency in the Third Age, but it is obvious that the social construction of aging plays a much larger role than popular culture might believe. The language of burden is often used in describing the way in which the recipient feels, but it might well be the case that it is a mutual feeling. "Caregiving studies have

⁶⁷ Cruikshank, *Learning to be Old*, 81.

⁶⁸ Cruikshank, *Learning to be Old*, 125.

documented a wide range of physical and psychological illnesses experienced by care providers,” illnesses to which women may already be susceptible. The female caregiver now has to manage her own aging process and the aging process of an older, and sometimes more needy, parent.

Cruikshank lays the foundation for a feminist gerontology that is attentive to the multiple factors that influence the way in which one ages. A notion of comfortable aging is distinct from successful and gerotranscendent models precisely because of its attention to the multifaceted experiences of the aging woman. Though many obstacles faced by women have been briefly mentioned above, there exists one more obvious barrier that goes unnoticed, yet its influence is unmistakable—the word gerontology. She notes that the word gerontology comes from the Greek word, *geron*, meaning old man.⁶⁹ Thus gerontology is effectively the study of old men, and it is no wonder, given that word and the history of medicine, and the myriad social and political impediments to women’s rights, that women are often forgotten or, worse treated differently than men. By limiting gerontological literature to the experience of males, the experience of the aging woman is further marginalized. A turn to a more critical model, such as comfortable aging, therefore, is a necessary evolution of gerontology. The model also previews the perspective needed for a theological ethics of aging for the US. Comfortable aging “emphasizes ease rather than external measurement”⁷⁰ and is connected to the individuality and autonomy of the aging agent. Comfortable aging recognizes the social, cultural, and political forces of aging while being attentive to the narratives of aging persons, especially women. Comfortable aging provides a

⁶⁹ Cruikshank, *Learning to be Old*, 188.

⁷⁰ Cruikshank, *Learning to be Old*, 4.

model for a way forward in constructing an ethics of aging, but there remain many more perspectives to be considered.

The sweeping historical overview has outlined several insights: the good life and health in ancient medicine were inseparable and held a functionalist or mechanistic view of the body; the functional assessment of health and the good life persisted into the Middle Ages and into the modern era; the psychoanalytical tradition of the early 20th century possesses the specter of that functionalist interpretation of the body and contends that the good life in aging is in part linked to one's contribution to society; late 20th century gerontologists continue in the tradition of making productivity and a functionally healthy body and mind requirements of aging well until a feminist perspective provides sufficient critique and offers a new model for aging well.

Healthy Aging In Medicine

When one wishes to explore the question of aging well today, a simple search is likely to yield a number of sources ranging from scholarly articles to blog posts and every credible or incredible thing in between—all of which can be quite confusing and sometimes contradictory to an individual seeking to uncover how it is that he or she may age well. Oftentimes what is revealed for living well within the medical community is an overwhelming amount of statistics that are indicative of healthy aging, not necessarily the question of aging well. These statistics keep with the tradition of Hippocrates in linking the functioning body to the good life, thus much of what is offered in this section will focus primarily on that mechanistic dimension of living well. The professional perspectives on aging well from The National Institutes of Health (NIH) and National Institute on Aging (NIA), Centers for Disease Control (CDC), and the Mayo Clinic emerge from a number of empirical studies, and constitute the foundation for current medical

conceptions of healthy aging. Such studies include the NIH and NIA's "Baltimore Longitudinal Study of Aging" (*BLSA*) and its follow-up report, "Healthy Aging: Lessons from The Baltimore Longitudinal Study of Aging" (*HABLSA*) and the CDC's "The State of Aging & Health In America 2013"⁷¹ (*SAHA13*).

HABLSA attempts to "identify the true effects of aging" and "separate factors such as disease, socioeconomic disadvantage, or lack of educational opportunity from the underlying biological or other mechanisms common to human aging."⁷² Using *BLSA*, the report analyzes and makes more widely accessible the older study's data. So, what then does the *BLSA* have to offer? This observational study⁷³ measures the changes that occur during the aging process: the biological, behavioral, genetic, and environmental factors insofar as they are responsible for changes, potential risk factors for later in life pathologies, possible interventions that may ameliorate the aging process, and the factors associated with healthy aging over time.⁷⁴ The two primary conclusions of the study will resonate with earlier remarks: "'normal' aging can be distinguished from disease," and "no single chronological time table of human aging exists, we all age differently."⁷⁵

⁷¹ Centers for Disease Control and Prevention. "The State of Aging and Health in America 2013." (Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2013.)

⁷² National Institute on Aging, National Institutes of Health, Department of Health and Human Services. *Healthy Aging: Lessons from The Baltimore Longitudinal Study of Aging*. (Washington, DC: National Institutes of Health, National Institute on Aging, US. Department of Health and Human Services, 2010), 9.

⁷³ The study does not conduct any sort of clinical trial; rather it conducts tests on voluntary patients on schedules that changes in accordance with the research subject's age.

⁷⁴ "Baltimore Longitudinal Study of Aging: Study Design and Measures," National Institute on Aging, National Institute of Health, Accessed July 6, 2015, <https://www.blsa.nih.gov/about/study>.

⁷⁵ NIH, *Healthy Aging*, 3.

The CDC's study differs from *HABLSA* in that it is public health-oriented, meaning that its focus is on the policy changes required to address the demonstrated needs of the aging population, understood by the study as the Baby Boomer generation.⁷⁶ The healthy lives of the aging are important insofar as they affect the lives of the entire society. It is here that the concern for the aging as integral to the success of the community comes into focus, a point to be taken up in the final three chapters. Aging well, then, is not only a matter of importance for individuals but for all persons, and therefore should inspire a public health responsibility for all. The primary impact to be had on the overall populace is economic: *SAHA13* estimates that by the year 2030, health care expenditures will increase by close to 25% and Medicare spending will nearly double from \$555 billion to \$903 billion in 2020 without accounting for inflation.⁷⁷ *SAHA13* demonstrates that while many persons develop chronic diseases later in life, there exist a number of diseases which present later in life but which can be prevented or mitigated during one's youth. Thus, the public health orientation of the study is intended to assuage the effect of the future aging population by examining the current aging population and addressing its needs.⁷⁸ Those needs tend to be characterized by the negative effects of chronic disease. According to *SAHA13*,

Chronic diseases can affect a person's ability to perform important and essential activities, both inside and outside the home. Initially, they may have trouble with the instrumental activities of daily living, such as managing money, shopping, preparing meals, and taking medications as prescribed. As functional ability—physical, mental, or

⁷⁶ The study is largely based on how current metrics match up to the *Healthy People 2020* initiative sponsored by the Office of Disease Prevention and Health Promotion under the auspice of the US Department of Health and Human Services. See *SAHA13*, ii.

⁷⁷ CDC, "State of Aging and Health," 5.

⁷⁸ CDC, "State of Aging and Health," 5. "If a meaningful decline in chronic diseases among older adults is to occur, adults at younger ages, as well as our nation's children and adolescents, need to pursue health-promoting behaviors and get recommended preventive services."

both—further declines, people may lose the ability to perform more basic activities, called activities of daily living, such as taking care of personal hygiene, feeding themselves, getting dressed, and toileting.⁷⁹

All of these factors are believed to have a direct correlation to the enjoyment of life. The loss of meaning and enjoyment of life can contribute to other conditions (i.e. depression) in later years that can work together with the underlying chronic condition to further erode one's joie de vivre. To combat these and other problems, both the CDC and NIA have offered a series of tools for improving quality of life, and to whether the underlying condition diminishes one's physical or mental wellbeing.

Frequently found in discussions about aging well are the following words or phrases: healthy behaviors, longevity, productivity, self-reported health, and social connectedness.⁸⁰ Together they ultimately lay the groundwork for what the CDC addresses as wellbeing. Though wellbeing is examined through the lens of public health, it is important to highlight the tendencies of such research in describing what the professional medical organizations would consider as living well, or at least healthy living. The CDC admits that there is no mutually agreed upon definition of wellbeing, but points to particular characteristics that correlate to indicators or metrics within medicine. An absence increase, or decrease of those characteristic leads to a reduced level of wellbeing. Wellbeing is broken down into at least⁸¹ two categories, physical and mental.

⁷⁹ CDC, "State of Aging and Health," 3.

⁸⁰ "Health-Related Quality of Life (HRQL): Wellbeing Concepts," Centers for Disease Control and Prevention, Accessed July 3, 2015, <http://www.cdc.gov/hrqol/wellbeing.htm#three>.

⁸¹ "Health-Related Quality of Life (HRQL): Wellbeing Concepts," Centers for Disease Control and Prevention, Accessed July 3, 2015, <http://www.cdc.gov/hrqol/wellbeing.htm#three>. The CDC lists the following forms of wellbeing: Physical, Economic, Social, and Psychological. It goes on to list other core areas that contribute to self-

Physical wellbeing refers to the condition of the body in terms of fitness, average (not pre-hypertensive) blood pressure, fully functioning circulatory and respiratory systems, and generally standard vital statistics. Though the standard vitals change based on age, sex, and other factors, the health of an adult would be directly linked to a blood pressure reading between 90/60 mm/Hg and 120/80 mm/Hg, a pulse between 60 and 100 beats per minute, and a temperature no lower than 97.8 and no higher than 99.1 degrees Fahrenheit,⁸² all of which should sound familiar. Average weights, based on an average height for women and men, are not merely statistics; rather they represent a guideline for a healthy size according to the National Heart, Lung, and Blood Institute.⁸³ Vitals such as these are the current tools used to determine the physical wellbeing of an individual. Obviously, there is more to wellbeing than a series of numbers, but when the aging person engages in a conversation about wellbeing with today's medical professional or in the context of medicine, these are the metrics to which wellbeing may be reduced. If that is the experience of speaking with a physician about one's health, what can the aging patient do to ensure that she or he is in fact trying lead a healthy life?

According to the medical authorities addressed above, living well requires that one commit oneself to the so-called 'healthy' lifestyle. The CDC, NIH, American Heart Association (AHA), American Lung Association (ALA), American Diabetes Association, and numerous others conclude that diet, exercise, being temperate with alcohol consumption and refraining

perceived wellbeing: Development and Activity, Life Satisfaction, Domain Specific Satisfaction, Engaging Activities and Work.

⁸² "Vital Signs" US National Library of Medicine, National Institute of Health, Accessed July 3, 2015, <http://www.nlm.nih.gov/medlineplus/ency/article/002341.htm>

⁸³ "Calculate your Body Mass Index," National Heart, Lung, and Blood Institute, National Institute of Health, Accessed July 3, 2015, http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm The male patient, whose average height is 5 feet nine and one half inches, should be no more than 165lbs, while the healthy female adult whose average height is 5 feet 4 inches should be no more than 140lbs.

from tobacco products are the foundations for a good healthy life in aging. *HABLSA* stress that “exercise and physical activity are the cornerstone to almost every healthy aging program,” reminding the reader that *any* physical activity is integral to helping individuals “do the things you enjoy and stay independent as you age.”⁸⁴ However common this knowledge may be, or is believed to be, its repetition remains the singular foundation upon which most other health maintenance or improvement programs are designed. Yet, this seemingly obvious solution to aging well implicitly points to the myth that aging is inherently connected to disease: conditions such as heart disease, type II diabetes, hypertension, depression, and anxiety are believed to be inevitable manifestations of the aging process. Surely an inactive lifestyle will lead to weight gain and other issue when one ages, but the manner in which such information is presented can suggest that the problems faced by the aging are part of the aging process. This troubling connection feeds into popular perceptions about what it means to age, and unfortunately informs a segment of bioethicists who will be addressed below.

Mental wellbeing or mental health is defined as “a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”⁸⁵ Though mental health is a well-known issue, when it comes to the aging population the question focuses on a related yet different type of brain-related health, cognitive health. Healthy cognitive functioning includes language, thought, memory, planning and carrying out tasks, judgment,

⁸⁴ NIH, *Healthy Aging*, 15.

⁸⁵ World Health Organization. *Strengthening Mental Health Promotion*. (Geneva, Switzerland: World Health Organization, 2001), No. 220.

attention, perception, remembered (learned) skills, and the ability to live a purposeful life.⁸⁶

Taken together then the mentally and cognitively healthy person possess the following characteristics: absence of depression, possessing a generally cheerful disposition, maintaining a level of optimism and hopefulness, and lacking any signs of neuropathology such as dementia or Alzheimer's.⁸⁷ While some of these areas will be addressed in further detail in later chapters, it is important to note that a comprehensive consideration of pathologies that affect mental wellbeing will not play a large role in the remainder of this project. Such a study would require research into areas that are outside the scope of the dissertation. Attempting to address the myriad ways in which the aging person who suffers from a mental illness of such magnitude conceptualizes aging well is a task too monumental for most.⁸⁸

The CDC offers a program for addressing the question of mental wellbeing called *The Healthy Brain Initiative: A National Public Health Road Map to Maintaining Cognitive Health*. Cognitive health can be measured or assessed based on the degree of functioning within the focus areas mentioned above. It is the improvement or at least preservation of cognitive function that the CDC wishes to achieve; however, achieving it is quite elusive, even some nine years into the research. Though the CDC does not offer much in terms of how the individual can work toward aging well in view of cognition, the NIA offers its own solutions. These suggestions for

⁸⁶ Centers for Disease Control and Prevention and the Alzheimer's Association. *The Healthy Brain Initiative: A National Public Health Road Map to Maintaining Cognitive Health* (Chicago, IL: Alzheimer's Association, 2007.), 6.

⁸⁷ Centers for Disease Control and Prevention. "Mental Health Basics" <http://www.cdc.gov/mentalhealth/basics.htm> Accessed 7/3/15.

⁸⁸ A quick glance at the National Institute of Aging, partner of the National Institutes of Health, shows just how prevalent material on Alzheimer's and other forms of dementia is. <https://www.nia.nih.gov/health/publication/memory-cognitive-health>.

cognitive improvement are familiar: physical activity, exercise, and healthy eating, all of which are believed to be beneficial. Additionally, being involved in leisure social activities or more productive and structured activities have been linked to decreasing one's risk for dementia. The NIA reports that being more sociable helps to alleviate depression, and that setting goals and achieving them or at least working toward them reduces the risks of diminishing cognitive function.⁸⁹ Still, it remains to be seen if universally proven strategies for maintaining one's cognitive health are to be found.

Aging Well In Medical Ethics

The medical profession's understanding of health is limited to the physiological functioning of the person, quantified by a series of metrics. Yet, the notion of health promoted by medicine sometimes points to elements of a broader vision of the good life, (i.e. recreational activity, social engagements,). The proper role of medicine is, and should remain, the relief or prevention of suffering; however, when modern medicine moves "beyond the promotion and preservation of health into the boundless realm of general happiness,"⁹⁰ medicine demonstrates its moral dimension. To more proficiently address this moral dimension of medicine, I turn to biomedical ethics. Within biomedical ethics, there exist at least two schools of thought concerning the relationship between the good life and aging. One group considers aging to be a natural (nonpathologic) part of life that does not hinder one's fulfillment of the good life. At the other end of the spectrum are ethicists who interpret aging as a pathogenic impediment to the

⁸⁹ National Institutes on Aging. "Participating in Activities You Enjoy – More than Just Fun and Games: Tips from the National Institutes on Aging," (Washington, DC: National Institutes of Health, National Institute on Aging, 2015), 1.

⁹⁰ Daniel Callahan, "When Self-Determination Runs Amok" in *Intervention and Reflection: Basic Issues in Bioethics 6th ed.*, ed. Ronald Munson (Belmont, CA: Wadsworth, 2000), 229.

good life requiring therapeutic intervention. While there are ethicists who do not create such a dichotomy, the former and latter are representative of how aging is generally perceived. What is more problematic than the two camps existing is what they implicitly say about aging, namely that aging means end-of-life. Bioethicists do not focus exclusively on the Third Age; instead the aging are always viewed as near death, or in decline, thus the emergence of the two competing perspectives are respond to the underlying premise that aging is bad.

What needs to be kept at the fore, however, is the limited manner in which the discourse on aging persons is generally conducted in biomedical ethics. Presumed in the above section and in what follows is that a disparate population can be addressed as a homogenous group that progresses through aging in a uniform manner and whose needs can be met and problems resolved in a correlatively uniform way. The CDC and NIH are marginally more attentive to the diversity of experiences across the aging population⁹¹ than other resources. The biomedical ethicists, despite being categorized into two groups regarding perspectives on aging, provide more space for continued discussion of how aging well might be considered beyond a purely functional health assessment. Still, the two views, aging as natural and aging as disease, will show that within the biomedical ethics community there remains a tendency to discuss the physical health of the aging person as a primary indicator for his or her capacity for achieving the good life.

Aging As Natural

There is much debate about just how natural the aging process is given the occurrence of chronic disease, susceptibility to physical and mental decline, and other issues that tend to be associated with 'being old.' Research has shown that it is difficult, if not impossible, to draw a

⁹¹ This will be addressed in the next chapter regarding pharmaceuticals

distinct line between aging as a standalone non-pathogenic process and the diseases that happen to coincide with certain ages. Yes, there is a range of diseases typically present in older adults, but determining whether they are a result of the aging process or of other factors is challenging. For those who maintain that aging is a natural process, authors such as Daniel Callahan, Norman Daniels, and Leon Kass, turn to the cultural denial of mortality and the absolutization of life. Their collective approach to aging begins with categorically different premises than ‘aging as disease’ ethicists.

Among his many publications, Callahan is perhaps best known for his work on health care rationing. An uncomfortable topic regarding the aging population, rationing is often viewed as an extreme option when it comes to resource allocation in health care.⁹² Callahan maintains that aging is a natural part of life, an organic process shared by all forms of life, and that it in no way should be treated the same as a disease. However, his goal is not necessarily to defend the ‘aging as natural’ position theoretically so much as it is pragmatically – rationing among certain segments of the aging population can help improve the health care delivery system. Thus, Callahan’s position on the issue of aging is difficult to separate from his overall project, and may be more of a necessary element rather than impetus.

Framed by his belief that the aging population represents the most daunting health care problem of the coming years (in the 1980s, but still true today), Callahan advocated for re-imagining both the way in which medicine was understood in light of the aging members of society. A shift in medicine’s understanding of the aging population also required a fundamental

⁹² Callahan, Daniel. *Setting limits: Medical Goals in an Aging Society*. (New York: Simon and Schuster, 1987), 20. Callahan considers the aging population as those who are 65 and older. He accepts a separation of chronological ages similar to that of Neugarten and other advocates of the Third Age. For Callahan, there are the young old (65-75), the old-old (75-85), and the old-old (85 and above).

change in how aging itself was understood, argued Callahan. Aging had to be reconsidered socially, culturally, politically, and medically.

First, recognizing this potential dilemma in resource allocation in the 1980s, Callahan argued that what was needed was “a common conviction that old age has meaning and significance,” where meaning includes “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 inner self and the outer world.”⁹³ The significance of aging to which Callahan refers indicates “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 indispensable.”⁹⁴ The details of what Callahan deems to be meaningful and significant will not be addressed here but it is worth noting that much of what he suggests is a combination of theological insight, developmental psychology (see Erikson and Tornstam above), and virtues ethics (to be addressed in chapter three). Creating a new meaning to be sought for the aging person first requires a change in medicine’s one-dimensional functional assessment of aging, and a dissociation between aging and disease.

It is modern medicine—what it is capable of offering in terms of preserving, prolonging, and extending life—that contributes to the perception that the aging population is a threat to health care resource allocation. Modern medicine’s belief that “life, death, and illness can be scientifically dominated and pacified,”⁹⁵ must be overturned, lest the cultural denial of mortality

⁹³ Callahan, *Setting Limits*, 33.

⁹⁴ Callahan, *Setting Limits*, 33.

⁹⁵ Callahan, Daniel. *False Hopes: Why America's Quest for Perfect Health is a Recipe for Failure*. (New York: Simon & Schuster, 1998), 25.

persist to our collective detriment. In what Callahan classifies as the second era of medicine (today's era), there exists a constant quest to dominate nature. This Promethean complex nourishes a cultural belief that medicine and technology provide an unlimited horizon of possibility for improving the human condition. Not to be overlooked is the ever-important historical description of the good life in medicine that shows the good life and health are one and the same; with an increase in medical technologies, the good life becomes more widely available, but perhaps not more accessible given the cost of new technologies. Not until we move beyond this second era of medicine, which appears to involve a cultural and social shift as well as a medical one, will there be an effective change for the aging population. That third era will be characterized by what Callahan describes as sustainable medicine.

Integral to the creation of a sustainable medicine is the equitable distribution of health care “without undue strain, [and] affordable to the society” that embraces “finite and steady-state health goals” and moderates “aspirations for progress and technological innovation.”⁹⁶ The steady-state goals of medicine are rooted in the belief that there exists a threat to other social goods. Endlessly pursuing the “satisfaction of almost every individual health need, desire, and dream”⁹⁷ will ultimately cost an entire society too much, economically and socially. “Societal priorities such as education, jobs, and culture,”⁹⁸ will suffer from an insatiable thirst for medical technologies that enhance or extend life. Still, it is difficult to see how these priorities are distinct

⁹⁶ Callahan, *False Hopes*, 35.

⁹⁷ Callahan, *False Hopes*, 36.

⁹⁸ Callahan, *False Hopes*, 37.

from Callahan's economic concerns without his offering specific details on how those social priorities will suffer.

Moreover, steady state goals can be supported by emphasizing the notion that people in good health in a place like the United States have achieved a satisfactory level of health for now and the future. In order to achieve this shift in perspective, society must be reminded that health is a good, but not an absolute, good. With this comes the obvious yet extremely difficult-to-accept fact of human mortality. The acceptance that death is inevitable, suggests Callahan, is the biggest hurdle in helping to address the aging population. This begins with medicine and society's enabling of aging persons to live as comfortably as possible. Setting limits on the financial costs incurred by the public or by insurance companies is one of Callahan's proposals, though the details remain elusive in his vision of sustainable medicine. Such limits will not necessarily result in a correlative shortening of life expectancy or overall health because both physicians and Callahan agree that longevity and health are largely dependent on "earlier health habits and other factors."⁹⁹ If aging is something to be embraced rather than feared, what might that mean for the claim that there can be value or good found in aging?

Though it is clear that Callahan believes medicine cannot bring a profound happiness or offer meaning to one's life on its own, he does maintain that without medicine's ability to physically and mentally enable an individual's pursuit of the good life in aging, the experience of the Third (and Fourth) Age may be rather difficult. Integrity, wholeness, completeness—these are words that Callahan believes help to offer solace to the aging person who is confronted with the inevitability of death. He contends that solace that can further reduce the effects of the varied

⁹⁹ Callahan, *False Hopes*, 257.

types of suffering the aging person might experience, a thought not all too dissimilar from Tornstam's notion of gerotranscendence. In fact, Callahan invokes the idea of transcendence as being an important goal for the aging individual to achieve in the face of whatever decline in health he or she may be experiencing.¹⁰⁰ Being able to transcend requires the acknowledgment and acceptance of the fact that by the time one has entered into his or her mid 60s, and certainly by age 80, life's opportunities for "work, love, procreating and raising a family, life with others, the pursuit of moral and other ideals, the experience of beauty, travel and knowledge"¹⁰¹ have been presented and actualized or attempted, offering a sense of completion. That completion allows for appreciation and value to be made of the aging process. Up to this point, Callahan's remarks on the good life in aging do not oblige an aging person to serve others as was the case with most other authors above, but he leaves open the possibility of such an interpretation in his turn to kinship, specifically with the next generation(s), as a practice in which the aging person should engage in to feel more complete. Such relationships can help to fill help to fill the void when the aging parent is no longer needed in the same ways as he or she once was. Still, Callahan is cautious about reducing the role of the aging parent to caring for grandchildren and offering life advice to their children, but some level of engagement with others remains important for the aging individual. Surely, a longer life may be what the aging person wants, a desire that may be supported by his or her family and friends, but it is not necessarily the case that a shorter life, or not-so-long later life is "a self-evident evil; it may at worst be a regrettable

¹⁰⁰ Callahan cites the work of Eric Cassell.

¹⁰¹ Callahan, Daniel. *Setting Limits: Medical Goals in an Aging Society*. (Washington, DC: Georgetown University Press, 1987), 66.

loss.”¹⁰² Upon establishing the kind of value to be found in the aging process, and planting the belief that a prolonged life is not necessarily the best life, Callahan moves to address the question of health care rationing.

In an attempt to justify that health care for the aging should be rationed, Callahan asserts that this is to be done not in a dehumanizing way. The practice is not intended to be discriminatory; instead, the limits imposed on the aging intended to establish a more equitable distribution of resources in light of the community’s overall health care needs. What is routinely allocated to the aging should be evaluated in light of its efficacy: Acute care, though ‘necessary,’ may not improve one’s overall quality of life. As a first step in rationing health care distribution Callahan suggests that improvements in primary and preventative care must be made so as to mitigate the potential negative health outcomes that aging persons may experience. Compression of morbidity, the shortening of the time from terminal diagnosis to death, is a potential step forward in improving the overall quality of life without unnecessarily protracting illness or prolonging life, but this appears to be more in line with an ethics of dying well rather than aging well. The health care system as whole should do its best to limit suffering, embrace the accomplishment and value of living into old age, and create the space for comfort and enjoyment rather than extending life for the sake of extending life.

Similar to rationing health care is Norman Daniels’s belief that health care should have limits. Well known for his interpretation of just and unjust health inequalities, he asks the following question concerning the aging population:

How do we treat age groups fairly within distributive schemes, such as health care systems? What is a just allocation of resources to each stage of life, given that needs vary

¹⁰² Callahan, *Setting Limits*, 74.

as we age? When is a distributive scheme age-biased in an unfair way? Is age itself a morally permissible criterion for limiting access to new technologies?¹⁰³

Daniels does not see the aging population as a threat to the healthcare system itself, but rather a group that poses potential harm to other groups of persons. It is fairness to others, not the inherent value of the experience of aging that leads to Daniels' position that aging is not a pathology to be cured. For Daniels, health is of special moral significance because it is a controlling factor in one's ability to participate in society, but health care cannot and need not "be a bottomless pit."¹⁰⁴ Preventative and acute care, are for Daniels important as they concern the functioning of the person. Enhancement and prolongation of lives that cannot proportionately contribute/function, however, are not germane to health care distribution. Daniels echoes the earlier contributions on functionality and the aging vis-à-vis self-worth and value. Despite the positive elements of his work – asserting that aging is not a disease, and life is not to be absolutized or preserved at all costs – Daniels continues in the tradition of those whose comments on the aging do not move beyond the aging person's ability to contribute to society. Participating in society, as has been stated on numerous occasions above, is important, and will later be shown to be central to an ethics of aging; however, defining the aging person by his or her contribution cannot be the first and only way in which the aging person is understood.

Although Daniels believes that health care should be distributed justly or equitably, he acknowledges that inequitable distribution is partially caused by the consumption of resources by the aging. It is Daniels' conceptualization of a prudential lifespan that defends him against the

¹⁰³ Daniels, Norman. 2006. "Equity and population health: Toward a broader bioethics agenda." *Hastings Center Report* 36 (4): 22-35.

¹⁰⁴ Norman Daniels. "Justice, Health, and Health Care: Medicine and Social Justice" in *Contemporary Bioethics: A reader with cases*, eds. Jessica Pierce and George Randels, (New York: Oxford University Press, 2010), 389.

critiques of ageism, but as with Callahan, it is difficult to say whether his framework is targeting the aging. In his account of a prudential lifespan Daniels reminds the audience that individuals age and experience aging differently, an allusion to the developmental framework of Erikson adapted by gerontologists. Starting with this allusion to the developmental tradition reminds the Third Agers and younger people alike that individual needs will change over time. Throughout one's developmental progress, needs will change; over the course of time the satisfaction of those needs will yield an equitable distribution of resources. Balanced compromises or tradeoffs made throughout the course of life constitute Daniels' view on a prudential lifespan. Such tradeoffs are not fully described by more than those decisions that "make life better as a whole [or] better than the alternatives,"¹⁰⁵ but the underlying point of this framework is to create a more just distribution in view of scarcity. Distribution "from a slice-of-life perspective seems unfair," argues Daniels and will be viewed as "egalitarian in an over-a-lifetime view."¹⁰⁶ The slice-of-life perspective requires that one is capable of conceptualizing his or her own vision of the good life and making the decisions required to attain that life both in the moment and over the course of one's life. This perspective is similar to that of Tornstam's gerotranscendent view which requires an individual have the capacity for conceptualizing a more comprehensive notion of the good life looking forward and backward while satisfying that good life in the present moment. Still, Daniels does not suggest that the resources be limited simply because one has aged; rather, the aging should willingly ration resources as a result of a gerotranscendent notion of the good life.

¹⁰⁵ Daniels, Norman. *Just Health Care*. Studies in Philosophy and Health Policy. Cambridge [Cambridgeshire] (New Work: Cambridge University Press, 1985), 174.

¹⁰⁶ Churchill, Larry R. 2005. "Age-rationing in health care: Flawed policy, personal virtue" *Health Care Analysis* 13 (2): 137-46.

Bioethicist and physician Leon Kass further supports the claim that aging is a natural part of life. Like others in the ‘aging as natural’ camp, he believes that there are no real cures for aging—mortality will always win. However, he does suggest that there are different ways in which the condition of the aging person can be improved personally, experientially, and socially. Kass raises a theological question that also challenges cultural feelings about aging and death: “Should we, partisans of life [members of the Jewish faith], welcome efforts to increase not just the average but also the maximum human lifespan, by conquering aging, decay, and ultimately mortality itself?”¹⁰⁷ For Kass, the problem rests with the culture in which we live, the culture that wishes to extend life through medical technologies without ever considering what the ramifications might be or even what the limits of such extensions should be. His critique is of a culture that shies away from moral evaluation. He is willing to consider a reasonable lifespan but notes that the problem is defining what a reasonable lifespan is. Perhaps such a lifespan can be described this way:

Time needed for our plans and projects yet to be completed? Some multiple of the age of a generation, say, that we might live to see great-grandchildren fully grown? Some notion—traditional, natural, revealed – of the proper lifespan for a being such as man?¹⁰⁸

However, he concludes that there is no answer to the question of what defines reasonableness in the realm of extended lifespan, so how then can we advocate for something that is unprincipled? The unknown boundaries of such technologies are but one problem, another being a consumeristic culture’s talent for generating ‘needs.’¹⁰⁹ A consumer culture that fabricates new

¹⁰⁷ Kass, Leon. R. 2001. “L’Chaim and its Limits: Why not immortality?” *First Things* (New York, N.Y.) (113):17.

¹⁰⁸ Kass, “L’Chaim and its Limits,” 17.

¹⁰⁹ Consumer culture and its impact on medicine re: aging is largely the subject of the second chapter. For a more detailed discussion refer to Chapter Two, section 2.

needs only capable of being met by life extension or life improvement technologies will never be existentially or physically satisfied. Couched in different terms, Kass's analysis suggests that there continues to be a cultural obsession with the functionality of the body as an indication of the good life or happiness. Merely prolonging the life in some state of health is perceived to be better than living in a condition of disease of less than optimal health, or worse having lived well and died. How then might aging be reconsidered so as to enable the aging person's continual attainment of the good life in aging?

Attempting to find the good in the experience of aging in view of finitude, Kass outlines four benefits of mortality.¹¹⁰ He asks if an increase in lifespan would yield a commensurate rise or extension in happiness. In other words, if I were to live an extra percentage of my current projected lifespan would the same goods continue to generate the same amount of good or happiness in the additional segment of the lifespan? Assuming I experience an average physical decline that comes with age, will skiing be as enjoyable to me at 95 as it was at 65? Probably not as I might not be able to ski at 95 – extending my lifespan from 65 to 95 may not necessarily bring about more good or more happiness. If the good life can be separated from an arbitrary number, and instead understood in terms of quality of life, moving to extend life ad infinitum may not appear so appealing. Seriousness and aspiration are Kass's next benefit of mortality; together they emphasize the impact that one can have on this life and this world when there is a definitive, albeit unknown, end to this life. Mortality can serve as a motivating force by ensuring that everything individuals do and accomplish in life has more substantial meaning. "For most activities, and for most of us, I think it is crucial that we recognize and feel the force of not

¹¹⁰ Kass, "L'Chaim and its Limits," 17.

having world enough and time”¹¹¹ concludes Kass, even though there may be certain activities in life that do not require such motivation. Third, beauty and love bring about an appreciation that is contingent upon not knowing if one will experience such a sight or feeling ever again.

Regarding love, he asks how deeply one could possibly love another knowing that there is no end in sight. Despite the harshness of such a hypothetical question, is it not true that the preciousness of time makes certain moments more profound than an otherwise timeless type of experience? Lastly, Kass addresses what he terms the beauty of human character: virtue and moral excellence. Mortality enables the individual to transcend creatureliness and act on behalf of “the good and noble.”¹¹² If one were immortal, there would be no virtue, no pursuit of justice, or the good, according to Kass. Living authentically cannot be accomplished, according to Kass, without being aware of and accepting one’s finitude. He concludes his discussion of the four benefits:

Mere continuance will not buy fulfillment. Worse, its pursuit threatens--already threatens--human happiness by distracting us from the goals toward which our souls naturally point. By diverting our aim, by misdirecting so much individual and social energy toward the goal of bodily immortality, we may seriously undermine our chances for living as well as we can and for satisfying to some extent, however incompletely, our deepest longings for what is best.¹¹³

While the language and insight of Kass are noticeably different from the authors mentioned above, his contribution to the ‘aging as natural’ end of the biomedical ethical spectrum is important. He critiques the cultural denial of mortality and is cautious about the perceived relationship between medical technologies and the good life. Though it is possible to interpret his

¹¹¹ Kass, “L’Chaim and its Limits,” 17.

¹¹² Kass, “L’Chaim and its Limits,” 17.

¹¹³ Kass, “L’Chaim and its Limits,” 17.

work as that of a bioethicist who groups the Third Agers into the end-of-life category, the way in which he addresses mortality suggests otherwise. Instead of offering an underdeveloped ethics of dying well he speaks to the good that can be experienced in aging, and how the aging person may be able to achieve it. While the aging person must be aware of mortality, this does not mean that he or she should give in to mortality and never seek treatment. Negotiating the good life in aging is in part a question of medicine and medical technology, but aging well cannot be achieved solely through a diet, a medication, or a surgical intervention.¹¹⁴

Aging As Disease

While the authors addressed in this section can be categorized as believing that aging is a disease, it is important to note that there exists a wide array of perspectives within this school of thought. To say that aging is a disease means that there are pathologies that present during the aging process attributable to the aging process itself. For example, hypertension is assumed to happen to almost every Third Ager—outside of a real medical abnormality, one does not suffer hypertension as a teen or younger adult. It is this type of belief that a medical condition is a chronological inevitability that serves as the basis for the approach of those who believe aging is a disease. A majority of authors who view aging as a pathology contend that the pathological nature of aging establishes a moral imperative to treat, avoid, or cure aging. Two such individuals are Arthur Caplan and Peter Singer.

A former associate director of the Hastings Center and widely published ethicist, Arthur Caplan currently serves as the founding director of the Division of Medical Ethics at New York University's Langone Medical Center's Department of Population Health. In a 2005 article, "Death As an Unnatural Process," Caplan names the popular voices who oppose his

¹¹⁴ Leon R. Kass. Washington Post. 2005. "Challenges of aging society are economic and ethical" *Deseret News*.

interpretation of the aging process, notably Callahan and Kass, and places the onus on them to explain their misguided understanding that aging is natural. Caplan argues that his critics' opinion that aging is natural and not pathogenic contradicts the very definition of the type of change demonstrable change witnessed in aging. Such a change, he argues, "is inevitably defined as constituting any morbid process in the body," where a morbid process is related to a diseased state of the body.¹¹⁵ These morbid changes are how the age of a corpse is determined by a coroner in an attempt to support his opinion that can only be classified as a disease. Disease, Caplan argues, is comprised of the following elements:

One criterion is that the state or process produces discomfort or suffering. A second is that the process or state can be traced back to a specific cause, event, or circumstance. A third is that there is a set of clear-cut structural changes, both macroscopic and microscopic, that follows in a uniform, sequential manner subsequent to the initial precipitating or causal event. A fourth is that there is a set of clinical symptoms or manifestations (headache, pain in the chest, rapid pulse, shortness of breath) commonly associated with the observed physiological alterations in structure. Finally, there is usually some sort of functional impairment in the abilities, behavior, or activity or a person thought to be diseased.¹¹⁶

Such an explanation of disease is not all that different from other widely accepted definitions of disease, i.e. Christopher Boorse.¹¹⁷ Caplan offers two caveats to this definition: there are always exceptions to the ways in which disease presents, and not all diseases will actually satisfy the

¹¹⁵ Caplan, Arthur L. 2005. "Death as an unnatural process." *EMBO Reports* 6 (1S): S72-5. S73.

¹¹⁶ Caplan, Arthur L. *If I Were a Rich man could I Buy a Pancreas?: And other essays on the ethics of health care.* (Bloomington: Indiana University Press, 1992), 205.

¹¹⁷ Christopher Boorse. "A Rebuttal on Health," in *What is Disease?*, eds. J.M. Humber and R.F. Almeder. (Totowa, New Jersey: Humana Press. 1997), 3-134 "A disease is a type of internal state which is either an impairment of normal functional ability, i.e. a reduction of one or more functional abilities below typical efficiencies, or a limitation on functional ability caused by environmental agents."

definition upon which his claims are based.¹¹⁸ Thus, there is in fact nothing ‘normal’ about aging, and that once one enters adulthood those conditions that are may otherwise seem natural are, in effect, diseases. However, these arguments are circular and seem to evade any ethical dimension of the question at hand. For this, we must turn to Caplan’s other works.

In an essay entitled, “Is Aging a Disease,” Caplan articulates why there is a question as to whether or not aging might be considered natural. He explains that aging is common, and “occurs with a statistical frequency of one hundred percent.”¹¹⁹ Surely, Caplan has addressed a convenient way in which one can rationalize his or her thought that aging is natural—it happens to everyone, all the time, much like the above-mentioned statistic about mortality. However, this simple approach to the argument is insufficient and not the primary culprit in the eyes of Caplan. Instead, he focuses on other more powerful notions that underlie those with whom he disagrees. Those other ideas supporting the naturalness of aging are “design, purpose, and function.”¹²⁰ Quickly he dismisses the design argument by offering examples of tools and bodily organs being capable of doing that for which they were not designed. Thus, purpose and function remain as arguments to be defeated. Purpose in aging, he believes, has theological or philosophical roots, and given the Judeo-Christian history of the US, it would make sense that many people would hold a belief that God’s designing the aging process established aging as part of the natural process of life. As a result of this perspective, the aging process and its effects are widely, albeit unwittingly, seen as reminders of human frailty, fallibility, and mortality. Caplan concludes that

¹¹⁸ Such a remark about the universality of presentation is a not-so-veiled rebuttal to what will be seen below as a foundational element of those who are critical of Caplan.

¹¹⁹ Caplan, *If I were a Rich Man Could I buy a Pancreas?*, 197.

¹²⁰ Caplan, *If I were a Rich Man Could I buy a Pancreas?*, 199.

despite the popularity of such a theological conviction, it carries no weight in the medical profession and should be cast aside as a baseless argument meant to undermine the pathogenic essence of aging. However, Caplan overlooks the importance of such deeply embedded cultural convictions, and his response is dismissive rather than critical or engaging. To say that because a belief related to one's perspective on health care is irrelevant or inconsequential because it comes from a theological tradition undermines a majority of biomedical ethical texts and makes Caplan appear unprepared to address this important component of bioethics. Finding a purpose and understanding one's function, as has been shown above, are integral in most discussions of aging and aging well, yet Caplan dismisses them because their roots are in a religious or philosophical tradition.

In addition to Caplan, a prominent voice in biomedical ethics belongs to Peter Singer. The utilitarian ethicist widely known for his positions on animal rights, controversial views on third trimester abortions, and stem-cell research, has recently taken strides in promoting the rhetoric of aging as disease and a Promethean response. In that article Singer argues that the aging process limits an individual's capacity for happiness and capacity to contribute to the happiness of others over time. "So, instead of targeting specific diseases that are much more likely to occur when people have reached a certain age, wouldn't a better strategy be to attempt to forestall or repair the damage done to our bodies by the aging process?"¹²¹ Singer believes that anti-aging technology will improve both in efficacy and availability across the socioeconomic spectrum, a preposterous claim given the current state of healthcare distribution. Of course, there

¹²¹ Singer, Peter. "Should we Live to 1,000?" Project Syndicate (online). Accessed June 23, 2015. <https://www.project-syndicate.org/commentary/the-ethics-of-anti-aging-by-peter-singer>

exists the possibility that over time life-extension technology will become more widely available and perhaps accessible as the supply-demand curve flattens, but critics remain rightly skeptical.

In a 1991 essay, “Research into Aging: Should it be Guided by the Interests of Present Individuals, Future Individuals, or the Species,” Singer argues that the aggregated utility or happiness of the population would be hurt by a radical extension of the lifespan. Singer poses a hypothetical scenario in which a scientist is ready to test a new medication that drastically retards the aging process to the point when a person can live to 150 while maintaining the happiness or utility of the average 60 or 70-year-old. Should society encourage this research? At the time of writing, Singer believed that from a utilitarian perspective it would be better to have a smaller group of people with a higher level of utility than a larger group with a lower average level of utility. In other words, it is best to have 10 aging persons with a happiness level of 8 (on a scale of 1-10, 10 being the highest) than 25 aging persons with a happiness level of 7. While more people may experience some happiness in the latter, the greatest amount of happiness is higher in the former. Thus, it would be best to avoid the hypothetical development of a medicinal technology that could increase the number of individuals living into very old age for the sake of their aggregated happiness. However, what if it was the case that the technology commensurately improved happiness with age as modern research suggests? Then we can see how a shift in perspective is possible for Singer.

Adding the fruits of modern anti-aging research to the hypothetical scenario outlined above might urge Singer to change his conclusion. Research shows that humans can potentially live better (read: younger feeling) lives later in life. If this were the case then Singer would have to approve of such technology being widely used, for it would not diminish the overall happiness

of the whole. For Singer, there is no question as to whether or not age should be combatted—it must so because it poses a threat to an individual’s happiness regardless of whether he or she is in the Third or Fourth Age. What anti-aging scientists have shown is that there is a real possibility of being able to ensure a better quality of life for those living into radically later years (i.e. 80s-early 100s) than those individuals would have had in their 60s. It becomes slightly clearer then that with such an improvement in collective happiness, there is nothing wrong with seeking to extend life, other than the effects of indefinite life-extension technologies on a cultural denial of mortality in the face of scarce medical resources. This, however, seems to not be a concern of Singer per se. Singer at least minimally concerns himself with one’s ability to contribute to the happiness of others, so presumably the increase in quality of life and life years would enable an individual to contribute to the happiness of others. However, entirely overlooked is any discussion of what life-extension therapies mean for the rest of society regarding the distribution of scarce medical resources, the allocation of research dollars, and who will be afforded the opportunity to live a radically longer life.

It would be unfair to characterize either Caplan or Singer as suggesting that they absolutize life.¹²² However, the manner in which each approaches the issue of aging does point to a trend that is best not understood as absolutizing life, but rather as absolutizing optimal health, which, interpreted for the aging, returns to the functional understanding of the person. By focusing on the pathogenic dimensions of aging, both authors suggest that it is returning the body to ‘normal’ or maintaining ‘average’ levels of functioning that should be valued. Perhaps the aging are victims of coincidence given that achieving optimal health somehow becomes

¹²² Neither says, in these or any other works, that life should be preserved ad infinitum, but a careless and limited reading of either might lead potential audiences astray.

increasingly difficult as one ages, but being viewed and described in terms of their physical and cognitive function is no coincidence. The mechanistic understanding of the body and subsequently of the aging body and its ability to achieve a healthy and good life has been incorporated, knowingly or not, into segments of medicine and medical ethics. Again, this is not to say that the functional aspect of the human body should be pushed aside in favor of a purely abstract formulation of the good life; instead, it is to highlight how such a reductionist approach can and has been damaging to how two professional disciplines talk about and conceptualize the question of aging well. Furthermore, this view of the aging person as aging body as deficient and unproductive feeds into other narratives to be addressed in chapter two that, when studied together, reveal a rather troubling cultural image of aging and how to age well. The health-related information one receives is an important part of aging well, and does not change much as one matures. ‘Take care of yourself, watch what you are eating, only drink in moderation, try to walk at least 30 minutes per day,’ are mentioned in conversations that Third Agers had in their 20s with the same goal in mind: age well. In the Third Age, however, aging well requires different attention to health and is generally accompanied by a different type of lifestyle complete with its own psychological adjustments.

Women, Medical Ethics, And Aging

In the introduction to *Mother Time: Women Aging and Ethics*, Margaret Urban Walker explains that more research concerned with “gendered effects of aging on moral standing for both men and women, on interactions of aging with other factors that define social privilege or devaluation,”¹²³ is necessary so as to not continue to impose a distinct moral risk on women.

¹²³ Walker, Margaret Urban. *Mother time: Women, Aging, and Ethics*. (Lanham: Rowman & Littlefield Publishers, 1999), 2.

That moral risk concerns the dignity, agency, and identity of women, and is a risk that can only be adequately identified and addressed by women.¹²⁴

Given the influence of the work of Callahan, it is worth making note of a direct retort to his *Setting Limits* by Nora Bell. She argues that Callahan overlooks how age-based rationing will disproportionately impact women. Because “the so-called ‘frontier’ of old age extends endlessly for many more women than men,”¹²⁵ women who would have normally lived longer will bear the brunt of Callahan’s proposed rationing.

Of the many issues taken up by Bell, her primary concern remains Callahan’s lack of attention to the experiences of aging women, with the exception of his attention to women as caregivers in later life. Her critique is specifically of Callahan’s notion of a tolerable death,¹²⁶ and is directed toward its tri-partite definition:

A tolerable death is this: the individual event of death at that stage in a lifespan when (a) one’s life possibilities have on the whole been accomplished; (b) one’s moral obligations to those for whom one has had responsibility have been discharged; and (c) one’s death

¹²⁴ Walker, *Mother Time*, 2.

¹²⁵ Bell, Nora K. 1989. “What Setting Limits may mean: A feminist critique of Callahan's *Setting Limits*” *Hypatia* 4 (2): 170.

¹²⁶ Callahan’s “Age, Sex, and Resource Allocation” in *Mother Time* was written after Bell’s critique of tolerable death and is therefore not part of Bell’s comments. In “Age, Sex, and Resource Allocation,” Callahan takes up the question of rearranging the health care system in the face of rationing (not the question of a tolerable death per se) so as to better take care of the elderly, both men and women alike. While resource allocation is not necessarily the notion being addressed above, it would be a disservice to Callahan to label him as ‘not concerned with elderly women.’ Callahan does not advocate for special consideration being given to women alone on the grounds of further issues of unjust distribution, but does note that the improvements to the health and health care of the elderly can be made with changes in the socioeconomic conditions that contribute to health – something with which feminist authors can identify. Callahan in fact responds to critiques akin to Bell’s, and apologizes for such an oversight. However, he does not fully back off of his age-based rationing in health care despite the known differences among elderly men and women in terms of longevity and resource consumption. He maintains that elderly women will disproportionately need more medical care than men, and while this is problematic, endless pursuit of medical technologies, even if they do benefit women, cannot be continued at the risk of sacrificing the quality of care for all other members of society.

will not seem to others an offense to sense or sensibility, or tempt others to despair and rage at the finitude of human existence.¹²⁷

First, Bell considers the possibilities women have been offered in light of the fact that the possibilities themselves were constrained by sexist and ageist norms and practices. She argues that while Callahan's push toward a biographical understanding of life is a refreshing change, it proves to be counterintuitive and instead devalues women's concerns and reduces the possibilities of a woman to "servile functions."¹²⁸ This point resonates with the broader critique that the visions of aging well offered by many authors are those of serving others, but Bell's contention is that the serving, let alone the type of service, that women are expected to do is inherently degrading. The biographical definition of life is limiting insofar as the range of experiences for women are vastly different than those of men, resulting in an externally imposed handicap that trivializes any meaningful experience a woman may have, and likely will have by virtue of her living longer than her male counterpart. There is more to be experienced by women than men can even conceptualize because of their inability to see a woman as independent and having a longer lifespan. Bell's comments on Callahan's second point raise a practical question to this very day—if women live longer than men, and women have been in the work force for a shorter amount of time, how does the public view an older woman's consumption of resources, medical and financial, if she no longer has responsibilities to anyone but herself? The woman, then, becomes the primary subject of Callahan's limiting schema.¹²⁹ Bell considers Callahan's remark that death resulting from discrimination or indifference is unconscionable, but remains

¹²⁷ Callahan, *Setting Limits*, 66.

¹²⁸ Bell, "What Setting Limits May Mean," 173.

¹²⁹ Bell, "What Setting Limits May Mean," 175.

unconvinced that this parenthetical comment will influence the way in which the needs of women will or will not be met. The final and most confusing quality of Callahan's tolerable death causes Bell to reflect on whether or not the death of an elderly woman can ever not engender some sort of rage or despair. "Abuse, neglect, and exploitation include failing to provide the ill and fragile with minimal medical care, medication, and hospitalization,"¹³⁰ a problem that will assuredly affect women more than men if the age for rationing, as suggests Callahan, is based on the life expectancy of men. Fairness in healthcare allocation cannot be differentiated into fairness for some and not for all, a problem Bell believes Callahan does not address. Bell ends her critique with these profound words, "appealing to an age standard will make the deaths of women premature in every sense of the word,"¹³¹ and for that reason, there remains the need for a feminist critique of biomedical ethics in general, but specifically as it concerns the aging population.

In addition to targeted critiques, feminist voices in medical ethics are needed to help craft a vision of aging that navigates the space between 'aging as natural' and 'aging as disease.' Bell provides but one reminder that there are and will continue to be problems unique to women that require special attention. "In the US, women are twice as likely as are men to seek prevention services," and as a consequence of a patriarchal culture, women are "negatively and stereotypically portrayed as whiners, complainers, and hypochondriacs."¹³² Still, there are benefits from frequent contact with physicians despite what might be said of a woman's frequent

¹³⁰ Bell, "What Setting Limits May Mean," 175-6.

¹³¹ Bell, "What Setting Limits May Mean," 176.

¹³² Linda Gannon. *Women and aging: Transcending the myths*. (New York: Taylor and Francis, 2005), 52.

visits to her primary care physician. It is known that women have a higher frequency of acute trauma, physical illness, and are diagnosed with more chronic diseases than men, but what might not be known is that women “perceive their health to be poorer and have greater rates of disability.”¹³³ If some women already feel as though their health is in poor, the fact that the medical profession uses a standard metric that does not account for the individual experience of aging and that there is a widely held belief about age hastening a decline in health do not help women feel any better. An additional area of difference rests in the changes in menopause. Perhaps it is here that the feminine voice is capable of speaking to the discussion of natural versus pathogenic given the ways in which menopause has been reconsidered in recent years. Menopause has come to signify a developmental or social change in the woman that correlates to other personal, social, and economic aspects of the woman’s life that very well may not have anything to do with the physiological changes of menopause. Changes based on age have become part of a so-called “menopausal syndrome,”¹³⁴ that marks the end of a ‘normal life’ and the beginning of a soon-to and always-to-be diseased life of the Third and later Fourth Age. Linda Gannon provides a summary of how what is normal for aging men is abnormal for women because of causal links made to menopause:

In women, however, these are not regarded as diseases but as manifestations of an underlying disease process – the disease being femaleness. In aging men, osteoporosis is the purview of bone specialists, cardiovascular disorders of cardiologists, mood swings of psychologists, Alzheimer’s disease of neurologists, and all such disorders are treated with specific medications and/or advice on lifestyle modifications. In aging women, these disorders, as well as others, are deemed the consequence of menopausal hormonal

¹³³ Gannon, *Women and Aging*, 53.

¹³⁴ Gannon, *Women and Aging*, 68.

changes, and all are readily treated by a gynecologist who is likely to recommend hormone therapy as a panacea.¹³⁵

The commingling of menopause, disease, and aging¹³⁶ creates the space for other pathologies typically associated with women to be assigned a gender despite their occurrence in both sexes and at all ages. Gannon argues that osteoporosis is one such condition that is all too often only associated with aging women. “Osteoporosis is not a disorder associated with menopause,” she concludes, but rather a disorder that affects any person whose “lifestyle[s] preclude healthy bone.”¹³⁷ It is important to note that scientific¹³⁸ research has revealed a fundamental disconnect between menopause and overall health—women who are postmenopausal are generally less likely to suffer from diseases than younger women. While it remains true that certain disease may present later in life for women it is unfair and inaccurate to correlate the hormonal changes of menopause to declining health or to label a postmenopausal woman as one who will assuredly suffer from a list of diseases or chronic conditions.¹³⁹

In addition to the problems addressed by Bell and Gannon, the defining of health as it pertains to women is problematic. The WHO¹⁴⁰ has an ever-expanding definition of health that

¹³⁵ Gannon, *Women and Aging*, 69.

¹³⁶ Gannon, *Women and Aging*, 76-7. Gannon explains that the hormonal decreases during the period leading up to including and after menopause make it difficult to clearly distinguish between age and menopausal status, but that connecting the two is equally difficult.

¹³⁷ Gannon, *Women and Aging*, 169.

¹³⁸ Gannon, *Women and Aging*, 86.

¹³⁹ An additional topic to be taken up regarding menopause will be that of cultural norms of reproduction and motherhood. This will be addressed in the proceeding chapter. [Jean Dresden Grambs. *Women Over Forty: Visions and Realities* (Revised Edition). 40].

¹⁴⁰ “WHO Definition of Health,” World Health Organization, Accessed July 21, 2015, <http://www.who.int/about/definition/en/print.html>. “A state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity” World Health Organization.

makes the determination of an individual's health increasingly difficult. A feminist notion of health would look to include the characteristics of physical and mental wellbeing, but it would also include social and psychological wellbeing so as to more closely resemble what the WHO believes to be healthy. However, it remains to be seen how medical professionals could adequately judge one's social health as a dimension of overall health. Still, taking into consideration the ways in which women's health results from myriad factors and the manner in which it is treated (differently than men), brings to the table a necessary conversation partner for the currently held positions in medical ethics regarding aging women.

Conclusion

At that end of a long historical and medical assessment of the question of health and healthy aging at least two themes emerge: first, the good life in aging has historically been and continues to be linked to a functional understanding of the body and mind; and, that the good life in aging tends to oblige aging persons to perform an act or series of acts in order to find fulfillment or achieve a sense of completeness. To a lesser degree, the chapter has also revealed the tendency within medicine and medical ethics to associate the aging person with the discussion of the elderly or end-of-life questions. Modern medicine explains how it is that humans might be judged to be healthy or not, but reduces wellbeing to categories of anatomical, physiological, and biological health, overlooking what other disciplines have highlighted as integral to the wellbeing of a person in general, and the aging person in particular.

The functional assessment of the good life began with Hippocrates, but somewhere along the way health and the good life became separated. However, the functional or mechanistic interpretation of health remained prominent within medicine and found its way into parts of

gerontology and medical ethics. Medicine focusing on how the body works is not inherently problematic, but retrieving medicine's moral dimension that health is integral to the good life and finding that health is limited to the way the body and mind work limits what an ethics of aging can glean from a tradition that should more wholly inform such an ethic. Emphasizing the functionality of the body paves the way for a model of productive or successful aging that obliges aging persons to be of service to others, or, more broadly, contribute to society. In order to age well, then, the aging are told by some gerontologists that so long as the body and mind are functioning at an adequate level, the good life can be achieved after he or she does something for someone else. Attention to the health of the aging person is highlighted in the medical ethics literature. Whether it come from the 'aging as natural' or 'aging as disease,' the message from medical ethicists is that aging will always come with a decline in health; the only difference is in how to respond. This further supports the notion that the optimal functioning of the body and mind are all that matter when it comes to aging well. However, an ethics of aging cannot be based on the medical question 'what does your health enable you to do,' *alone* nor can it make the corollary claim, 'because you are healthy you should/must do...in order to achieve the good life in aging' because it reduces the good life to being physically or mentally capable of performing a task. An ethics of aging will, of course, include health, but its focus will extend beyond this chapter's descriptions of aging well.

Regarding the relationship between the aging and the end-of-life, much of the medical history shows that lifespan was such that today's Third Ager was much closer to death than just another phase of life in previous eras. Granted that longevity has changed, it is plausible that the connection between adulthood and death facilitated today's conceptions about the aging person

as the frail elderly. Looking to developmental psychology first, it is clear that Erikson leaves open the possibility for adding sub-stages of adulthood prior to the final stage of development, yet this is nothing with which Erikson concerns himself – there may be developmental changes, but nothing in Erikson suggests that there are real discernible differences between his 45-year-old adult and 64-year-old adult, but there is between the 45-year-old and the 85-year-old.

Gerontologists attempt to peer into that empty space left by Erikson, but the primary concern of gerontology remains the study of how people age and what might be helpful or hurtful in that process. The difference between the aging person and the elderly person is not parsed out entirely, but gerontological literature at least allows for further separation to be made. Medical ethicists on the side of aging as natural completely overlook the aging population and instead focus on the elderly, those facing the end of life, for the most part. Whatever good comes out of the belief that aging is natural is undermined by the lack of attention to the distinctions between the aging person and the older person who happens to be near death – a common problem in bioethical discourse. Biomedical ethicists who espouse the views of aging as pathogenic diminish the value of the aging life by suggesting that the goal of aging well is to continue to live and overcome whatever might make the aging process challenging. Feminist voices critique notions of health generated out of male experience and founded upon data that is decidedly male-oriented, and they take up the task of separating aging from disease by further investigating the aging process. The male-centered investigation, unfortunately, strengthens the connection between aging and the elderly/end-of-life. What is most troubling about the way in which the aging person is considered may stem from the influence of Erikson's schema and the language used by medical ethicists.

As has been explained, Erikson's model does not provide enough on its own for an ethics of aging. Thus, it is necessary to explore the possibility of sub-stages within Adulthood, sub-stages that cannot be reduced to the struggle between generativity and stagnation. If Adulthood truly is the generational link, there must be something of meaning and value beyond the achieved strengths of care (Stage 7) and wisdom (Stage 8). It is implausible to suggest that the period between one's fifties and eighties (Adulthood) can adequately be interpreted through one developmental phase given the experiences of that group, let alone today's changing demography. This problem points to the larger critique leveled against Erikson and the developmental approach. The vagueness of the stages may be appealing to some as a general outline of psychosocial development, but the abstraction tends to reveal the "inherent fuzziness"¹⁴¹ in evaluating individual behavior. The stages themselves are vague in not identifying a specific age range, but also unclear regarding the terms (psychosocial crises and strengths) of each stage. While this more abstract and universally applicable approach is oftentimes seen as a strength of Erikson's theory cross-culturally, the generic Western experiences upon which he bases the stages are largely insufficient. More importantly, the vagaries of the stages can be seen as establishing a rather simplistic view of the aging experience. The strength achieved after stage 7, care, can mislead the aging person into believing that his or her psychosocial conflict can be solved with a new type of productive role in society. Similarly, the 8th stage's strength of wisdom suggests that the life experience of the sweeping range of adulthood can only be fulfilled when the individual has passed through the penultimate developmental phase. There must be an in between period, perhaps a sub-phase of Stage 7 that

¹⁴¹ Kenneth Hoover and Lena Klintbjer Ericksen. "The Future of Identity" in *The Future of Identity: Centennial Reflections on The Legacy of Erik Erikson*, ed. Kenneth Hoover (Lanham, MD: Lexington Books 2004), 7.

more adequately addresses the significant real-life changes experienced by the aging person: the transition out of the work place and into so-called leisure time, the changing role within the family structure, the shift in social or community involvement, and the recognition of mortality in the face of the body's changes.

These same limitations regarding Erikson's contributions to the good life in aging apply to Tornstam's model of gerotranscendence. He does not explain with any precision what gerotranscendence entails and how the aging individual might practice it so as to continue to move toward or realize the good life. Yet, the work of Erikson and Tornstam are integral in reminding the aging individual that aging itself need not get in the way of achieving the good life. The two actually suggest that as one develops through the later years, achieving the good life becomes easier to a certain extent. Of additional import is that Erikson and the gerontologists provide enough distance between aging and the end-of-life that the stages of development are not so closely associated with mortality. This added benefit of developmental psychology and gerontology can aid in nuancing the biomedical ethical discourse by further separating aging from disease and also offering something to be achieved in aging that might mitigate the sometimes-nihilistic views of the aging as natural advocates.

Within medical ethics the fundamental problem of not considering the Third Age as a separate group worthy of a focused ethic. Instead, most or all aging persons are lumped together with the elderly, a group that is very much different in demographic make-up and medical need—to be aging does not mean to be actively dying or near death. In Callahan and Daniels, we see that the only context in which the aging person is considered is that of the very old or elderly person who has chronic disease or faces the woes of end-of-life care. Callahan's age-based

rationing is a prime example in that he is not addressing the Third Age, rather those who are so close to the end-of-life that offering them more healthcare could be construed as futile for one reason or another. Callahan and Daniels do not address the needs of today's 65-year-old or even 75-year-old; instead their focus is on the old person who is near death. Regardless of the time in which it was written, the correlation between an older age and death underscores the way in which aging persons are considered. Though they represent the other end of the spectrum, Caplan and Singer, in their advocacy for life extension technologies and the overcoming of the disease of aging, also reduce aging to a process that only progresses toward sickness and death. The Third Age, in either school of thought, possesses no distinct value and only exists in relation to the end. Given changes in longevity, advances in technology, and other shifts in the lives of aging persons, it is fair to say that Callahan and Caplan alike are wrong, not only about age-based rationing and extending life ad infinitum, but also fundamentally wrong in their premise that aging persons are either healthy adults or frail and sickly elderly persons facing the end of life. The problem is not only one of the language used when it comes to the aging person, but also one of uncovering a substantive meaning of the good life for the aging person. A concept of the good life that is not immediately concerned with mortality is needed to develop a more appropriate ethics of aging. The Third Age, like any other period of life is natural, and, however fluid if referring to individual experiences, like the other stages should be treated as one particular stage in the context of the lifespan.

CHAPTER TWO

SOCIAL INTERPRETATIONS OF AGING AND LIVING WELL

Introduction

The good life in aging is as much informed by medicine and gerontology as it is by the very context in which those notions are mediated. Much of what is absorbed into the cultural context from medicine and gerontology is the relationship between the functional and productive body with the good life. Without a healthy body and mind, one cannot age well, and it is upon this functionalist notion of aging well that the American cultural response is built. Consumer culture pervades the very fabric of that social landscape which promotes varying notions of aging well. While it is not the purpose of this chapter to examine in detail the specific cultural influences on medicine and medical ethics vis-à-vis the good life in aging, it is important to note that what will follow regarding the impact consumer culture can have on an individual is not all that different than its effect on medicine and medical ethics. Pierre Bourdieu identifies the effect of one's culture on an individual's conception of the self and manner in which one moves toward self-actualization as the *habitus* of a given society. He explains the term as "a system of lasting transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, appreciations, and actions and makes possible the achievement of

infinitely diversified tasks.”¹ As much as the *habitus* affects an individual’s socio-cultural life and understanding of the self, so too are the social institutions to which one is exposed similarly informed. In the US, Bourdieu’s matrix of perception comprises political liberalism and free market capitalism, both of which, overtly and subliminally, esteem individual liberty. The individual, fully aware or not, acts in response to this framework built upon individual liberty that has very much penetrated the core of American identity. The ‘good American life’ is the individually-lived life to a certain extent—the good life is achieved through the individual’s hard work alone. The productive person has already been suggested as the one who is best suited to age well at least in terms of serving future generations, but the value of an individual who is productive must be explored further. In an economic sense, production in part means contributing through one’s work, which requires a certain level of functional health. However, one’s contribution to the economy and society can also be measured by what one consumes and what type of value one adds to society. For the aging person, the Third Age transition is mostly away from the work contribution and into alternative interpretations of productivity. Still, being productive, whether that be in the work place or being able to consume the goods advertised as essential to the good life, presumes an ability to function. That functioning, however, because of the American matrix of perceptions, not only implies but also requires that one does so independently. Accordingly, exploring the complicated history of independence is necessary when considering an ethics of aging.

Of the many discourses in which individual liberty or autonomy remains a central value, biomedical ethics provides a unique example of the manner in which the politico-philosophical

¹ Christine Firer Hinze, “What is Enough” in *Having: Property and Possession in Religious and Social Life*, eds. William Schweiker and Charles Matthewes (Grand Rapids, MI: William B. Eerdmans Pub., 2004), 177.

history of autonomy in the US has taken on a life of its own as it has evolved within the habitus of consumer culture. Thus, I will first explore the most prominent example of autonomy's value in biomedical ethics and then move to trace the historical contours of its entanglement with consumer culture. The prominence of autonomy as a central value in American culture led to a change in how the good life was to be understood, but for the purposes of the dissertation that shift will only be considered in light of consumer culture. A rather vague term, it is worth noting what is meant by consumer culture here: a culture that "is organized around the consumption and display of commodities through which individuals gain prestige, identity, and standing."² Such a culture is additionally capable of altering the very meaning of goods, further complicating the matrix in which the aging person acts and is acted upon. This capacity to change the meaning and value of goods suggests that identifying a more fixed understanding of the good life in aging is at least difficult if not impossible. A notion of aging well, contingent upon evolving socio-cultural values that are expressed in various social images and norms, requires both the recognition of the social milieu and a way forward.

The Historical Context of American Autonomy

As seen in the first chapter, medicine tends to focus on measurable physical and mental/cognitive metrics that mark standard or substandard levels of health, which indicate whether or not one is or is not living or capable of living the good life. Medicine generally concludes that if an aging person demonstrates healthy functioning then the individual is living well. There is little to no consideration of the other factors that determine one's health let alone the other influences that contribute to one's overall wellbeing. Some medical ethicists suggest

² Kutucuoglu, Kemal Y., Isil Arikan Saltik, Aytakin Firat, and Ozgur Tuncel. 2013. "Consumption, Consumer Culture and Consumer Society." *Jurnalul Practicilor Comunitare Pozitive* 13 (1): 182-203. 182.

that the longer one lives the less likely one is to live in a condition of being able to experience the good life. Absent from the first chapter's biomedical ethical discussion was the role played by the principle of autonomy in the satisfaction of the good life in aging. As a principle within biomedical ethics, autonomy has a history that is not born out of medicine or medical ethics; instead, it is a principle that precedes the emergence of biomedical ethics, a principle that is far more reliant upon the political and philosophical history of that term and its particularly American cultural context. For the aging person, the principle of autonomy espoused in biomedical ethics is not only about patient choice, but also about its place in the broader conceptualization of the good life in America.

Within biomedical ethics, the principles-based framework outlined by Tom Beauchamp and James Childress represents the preeminent, or at least a widely popular interpretation of autonomy, in the American context. Principlism, as it is commonly known, attempts to address the difficulty of decision-making processes within the biomedical ethical realm by offering a set of duty-values to be adjudicated in any case. Within this framework, outlined in *Principles of Biomedical Ethics*, Beauchamp, professor of philosophy and senior research scholar at the Kennedy Institute of Ethics at Georgetown University, and Childress, professor of ethics and director of the Institute for Practical Ethics and Public Life at the University of Virginia, identify the four principles to be used in resolving such dilemmas: Beneficence, Nonmaleficence, Justice, and Autonomy. Both beneficence and nonmaleficence are physician-oriented in that each place upon the physician the duty to work toward promoting the welfare of the patient while avoiding directly causing harm respectively. Moving to broader questions of healthcare delivery, Beauchamp and Childress turn to the question of justice, but submit that there is no single

approach to justice that is suitable for addressing the numerous problems that may arise in healthcare allocation. Questions of access to health care tend to emphasize egalitarian approaches to justice while specific instances of allocation employ more utilitarian thinking.³ Lastly, Beauchamp and Childress begin their discussion of autonomy with a rather straightforward etymological explanation of the term, citing its Greek meaning of self-rule/governance/law, defining it as encompassing “at a minimum, self-rule that is free from both controlling interference by others and from certain limitations such as inadequate understanding that prevents meaningful choice.”⁴ That self-rule means being able to hold a view, make choices, and act based on that which the individual values. The four principles aid in relevant decision-making scenarios, and in identifying four components of living well.

Central to the vision of Beauchamp and Childress is the moral significance of these principles in ensuring that the good of the patient is achieved in a medical context. Each principle attempts to present what the authors assert as normative claims indicative of a common (American) morality, though the context is limited to biomedical ethics. Being responsible to promote the welfare of another individual suggests that care and wellbeing are both central to one’s ability to achieve the good life. Beneficence requires that individuals be cared for physically and mentally, and that care be more broadly construed as access rather than simply the clinical setting. Similarly, nonmaleficence indicates that living well requires protection against

³ Beauchamp, Tom L., and James F. Childress. 2009. *Principles of Biomedical Ethics*. 6th ed. (New York, NY: Oxford University Press, 2009), 280. Invocations of egalitarian thinking arise when the authors address problems of access to health care, especially for those who are in greatest need or those who have experienced or continue to experience systemic discrimination – in these cases, it is important that a basic minimum threshold of health be established and maintained for all as a fundamental human right. Advocacy for utilitarian approaches to justice are demonstrated through a series of examples citing cost-benefit analysis as an integral part in decision and policy-making.

⁴ Beauchamp and Childress, *Principles*, 99.

harm – the health of the body and mind are to be safeguarded so as to protect the aging person from factors that might impede his or her fulfillment of the good life. Having fair access to health care resources and being afforded necessary resources formalizes beneficence and nonmaleficence in the public sphere – it is fair that all individuals be given the opportunity to obtain the services requisite to good health. The good health of the individual understood in this framework continues in the tradition of others in such a way that physical and mental health are essential to if not the primary components of the good life. Beneficence and nonmaleficence are intended to protect the optimal functioning of the individual so that he or she can live well. Claims about justice are relevant only insofar as they facilitate the functioning of the body and mind – they do not appear to have philosophical value unto themselves. Lastly, autonomy means that individuals are to be respected as self-directing persons capable of choosing how they wish to live. The ability to choose one’s life plan and move toward it, specifically in a medical context, establishes the implicit primacy of autonomy within the framework of principlism – the good life is known to the aging person, and beneficence, nonmaleficence, and justice function to support the agent’s autonomous fulfilment of that plan. However, Beauchamp and Childress argue that only when all four are upheld or equitably weighed in the decision or policy-making process of biomedicine is the totality of the good life considered. However, the principle of autonomy occupies a unique position among the four given the history from which it emerged.

As the preeminent value in American culture, autonomy’s place in biomedical ethics is commensurately privileged as the primary principle toward which patients, physicians, and other health care workers look for guidance. “Respect for the autonomous choices of persons,” argue

Beauchamp and Childress, “runs as deep in common morality as any principle.”⁵ While this may resonate with most, the priority of autonomy, albeit unintended by Beauchamp and Childress,⁶ has caused disagreement among biomedical ethicists about how and why autonomy should be valued over and against other ethical principles and the competing values of health care professionals and/or cultural values of patients. As Martha Holstein et al argue, it is “because this practice [applying abstract principles as rules in decision-making contexts] emerged in the American context, where individualism is central to national self-identity”⁷ that, quickly, autonomy was unofficially crowned the most important principle despite the Beauchamp and Childress’s repeated claims that it was equal to the others.

Although each of their principles can be seen as contributing to the good life, autonomy undergirds all three. Beneficence, note Beauchamp and Childress, is part of their basic understanding of morality that requires individuals to be treated as individuals capable of making their own choices, of determining their own lives, and determining how a course of medical treatment contributes to or detracts from one’s welfare.⁸ By avoiding doing harm to patients, nonmaleficence presumes the capacity for autonomy, thus serving as a minimum or threshold when it comes to preserving the rights of individuals. Justice presumes autonomy insofar as the desired good is articulated by the individual in question or is related to an established health

⁵ Beauchamp and Childress, *Principles*, 99.

⁶ Beauchamp and Childress, *Principles*, 99. The authors maintain while the first principle appearing in the text is autonomy it is not an indication of their opinion on the moral priority of autonomy. They argue that while their “critics suggest that the principle for respect for autonomy overrides all other moral considerations,” their work is in no way “excessively individualistic.”

⁷ Holstein, Martha B., Jennifer A. Parks, and Mark H. Waymack. *Ethics, Aging, and Society: The Critical Turn*. (New York, NY: Springer Publishing Company, 2001), 8.

⁸ Beauchamp and Childress, *Principles*, 197.

threshold. The good to be satisfied also belongs to the individual patient, not necessarily to the collective whole. So, what then is meant by the principle of autonomy that plays such a prominent role in biomedical ethical discourse and practice, and that serves to ground the other three principles outlined by Beauchamp and Childress? To answer this question, it is worth looking into the historical development of autonomy in America.

Autonomy In American History

Firmly fixed in American identity, individual liberty has a history that extends farther back than its articulation in the founding documents of the nation. Its prominent placement within those documents established individual liberty as a foremost American value and indeed identified a fundamental American characteristic. Individual freedom was the very essence of the newly formed nation's struggle for independence, and it was the clear path to establishing the good life. Independence was protected by a series of positive and negative freedoms that, when codified, concretized the essence of being American. Those freedoms, understood as fundamental rights, permeated all areas of social interaction and became the cornerstone of American enterprise, integral in the expansion and innovation of commerce. Precisely how individual liberty transitioned from being an identifying characteristic, however, to a value unto itself requires an examination of not only the founding texts of the nation, but also the context from which they were born and continued to evolve.

Liberty, defined as the state or condition of being free, is personal and political in the Declaration of Independence. As much as the Declaration is about the freedom one sovereign nation has from external political control, it is also about the freedom(s) of the individual members of that sovereign nation. The sovereignty both of the nation and the individual are,

according to the Declaration, founded in nature and divine will. When the Declaration lists divinely-inspired truths, which also happen to be self-evident, such as life, liberty, and the pursuit of happiness, the individual is given sufficient space for interpreting what constitutes an infringement upon his or her sovereignty. The relationship between those truths is most pertinent to the discussion here.

The interpretation of the order of these words can perhaps begin to shed light on the link established between liberty and the good life. Perhaps it is the case that the first two terms are requisite for the fulfillment of the third: Without one's life or health, one cannot exercise one's liberty, and therefore, cannot pursue happiness. This causal relationship places one's health as a foundational characteristic, a minimum condition making the good life possible. Another interpretation could be such that one's possessing life and liberty being about a state of happiness: When one is healthy and free, one is happy. Here, being a healthy and free individual automatically establish a state of happiness. In either case, both the health and liberty of the individual are essential to the good life. Though the proposed relationship among those qualities is speculative, the influence of these rights on American policy and social and cultural norms is not. The Constitution carries these American principles forward into a more robust and comprehensive articulation.

Continuing in the spirit of the American Revolution and the contemporaneous spread of anti-monarchy/pro-liberty political movements, the Constitution set out to organize the new American government with the goal of "promoting the general welfare, and securing the blessings of liberty."⁹ Upon completion of the statutes regulating the branches of government

⁹ United States Constitution. Preamble to the Bill of Rights. <https://www.archives.gov/founding-docs/constitution>. Accessed February 21, 2016.

and their respective processes and responsibilities, the Constitution moves into the more widely known series of positive and negative freedoms, namely the Bill of Rights. It outlines how it is that the welfare of the populace shall be protected through a series of liberties. An exemplary list of such liberties appears in the First Amendment,¹⁰ which affirms an individual's right to speak his or her mind, to openly practice any or no faith, to gather peacefully, and to have recourse to action should those freedoms be constrained in any capacity. Those freedoms as well as the claims regarding individual liberty in the general sense above and property, outlined in both the Fifth and Fourteenth Amendments, have come to symbolize the core of American identity. Yet, these liberties do not come with any justification beyond being touted as self-evident. The move from self-evident rights claims to the real-life manifestation of those freedoms was made possible by a political and philosophical context amenable to such a transition. Much of that context was informed by classical liberal thought.

A primary philosophical influence in early America was the classical liberal thought of John Locke. He adopts Thomas Hobbes' starting point of individual freedom and the pursuit of self-interest by invoking the language of 'state of nature.'¹¹ While Locke relies heavily on Hobbes in this regard, specifically on the question of moral individualism, Locke differs on the question of political individualism, which is apparent in his *Two Treatises on Civil Government*.

¹⁰ US Constitution. amend. I. "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech or of the press; or the right of the people to peaceably assemble; and to petition the government for a redress of grievances." <https://www.archives.gov/founding-docs/constitution>. Accessed February 21, 2016.

¹¹ Thomas Hobbes. "Leviathan" in *Ethical Theories: A book of readings*. 2d, with revisions. ed. (Englewood, NJ: Prentice Hall, 1967), 138. *Hobbes* outlines the state of nature as one of conflict noting that all individuals are inherently self-interested and that only in an effort to secure one's self-interest does an individual cede his or her freedom in the form of a social contract. An essential feature of the individual, liberty serves to both keep the individual free from external restraint and enable him or her to choose how it is that he or she wishes to live. Any influence that diminishes an individual's ability to do what he or she would do must be removed or at least mitigated.

Locke illustrates the way in which the political enslavement of the monarchical structure contravenes the natural order. Locke argues all individuals are born into “a state of perfect freedom” that enables them to direct their actions and to “dispose of their possessions and persons as they think fit, within the bounds of the law of Nature, without asking leave or depending upon the will of any other man.”¹² Later appearing in the founding documents, Locke’s language of natural law connects individual sovereignty to the divine, establishing that the limits capable of being placed upon an individual’s free will and liberty cannot come from the “inconstant, uncertain, unknown, arbitrary will of another man.”¹³ Here Locke shows that autonomy is essential to the individual, and history has shown that this claim, in relation to the good life, would only be fortified over time.

Upon grounding autonomy in a divine right or the natural law, Locke moves toward another facet of Enlightenment discourse – the role of reason and its relationship to freedom. Reason is the power by which the individual is capable of expressing his or her own freedom, that that use of reason “is able to instruct him in that law he is to govern himself by.”¹⁴ The capacity to reason to such an extent that the individual does not need to consent to the rules or laws of an external authority further supports Locke’s claims against forms of government that work toward undermining autonomy. No government can dictate how it is that the good life should be conceptualized; the government, upon receiving power from the governed, is only responsible for providing the environment in which the governed can move toward

¹² Locke, John, and Ian Shapiro. *Two Treatises of Government: And a Letter Concerning Toleration*. (New Haven, CT: Yale University Press, 2003), 102.

¹³ Locke, *Two Treatises*, 110.

¹⁴ Locke, *Two Treatises*, 126.

autonomously determined visions of the good life. Thus, Locke presumes that humans are social beings who come together to find mutual fulfillment while the individual is not stopped from pursuing his or her own good. Yet, the notion of communality begins to wane in view of property.

Property, both physical holdings and what an individual creates, is for Locke, the source of happiness. Those possessions are forms of self-expression that align with the autonomous individual's vision of the good life – having them makes one happy. Because such happiness, attached to possession or ownership, is integral to the good life, Locke's individual interprets activity in the producer-consumer cycle as a form of moral expression. This moral dimension of possession is furthered when Locke transitions to his notion of the moral self who *owns* material items, the work that one does, and the very manner in which one behaves.¹⁵ The moral self, the self that is expressed in what one owns and does, reshapes the way an individualistic drive for ownership might be understood. It introduces the idea that what one owns not only expresses what one believes to be symbolic of the good life, but the objects or one's behaviors are actually means to fulfilling the good life. Locke's individual moral self creates his or her own vision of the good life and then works to possess goods that contribute to the individual's good life metaphorically or literally. The relationship between autonomy and property as it contributes to an individual's satisfaction of the good life was an important step in a series of shifts that evolved with the growth of the American economy and economic spirit.

Locke's resulting proprietor model meshed well with the economic philosophy of Adam Smith that was adopted by the fledgling US. Smith's *An Inquiry into the Nature and Causes of*

¹⁵ Fairfield, Paul. *Moral Selfhood in the Liberal Tradition: The Politics of Individuality*. (Toronto, Canada: University of Toronto Press, 2000), 35.

the Wealth of Nations, commonly *The Wealth of Nations*, offered a new interpretative framework for Locke's proprietor model. As a tool for increasing productivity and profit, the division of labor brought about the following changes: workers earned more, consumers could acquire, and the organic market was empowered to respond to and generate new needs. Smith explains the expansion of the market,

When the division of labour has been once thoroughly established, it is but a very small part of a man's wants which the produce of his own labour can supply. He supplies the far greater part of them by exchanging that surplus part of the produce of his own labour, which is over and above his own consumption, for such parts of the produce of other men's labour as he has occasion for. Every man thus lives by exchanging, or becomes in some measure a merchant, and the society itself grows to be what is properly a commercial society.¹⁶

As a result of this expansion of commerce, wants and desires diversified, and were transformed into products to be exchanged on the market. Smith's explanation of 'value' suggests that the goods produced and exchanged on the market were very much understood in the Lockean fashion. Smith distinguishes two different meanings of value, in use and in exchange: the former "expresses the utility of some particular object" and the latter "the power of purchasing other goods which the possession of that object conveys."¹⁷ However, Smith notes that the things an individual may hold to be valuable do not necessarily possess any worth in exchange and vice versa,¹⁸ yet both are equally important – especially considering the subjective nature of what is valuable. Smith delineates the ways in which price and currency become the common language of commercial enterprise, but what remains important throughout is the individual's choice to

¹⁶ Smith, Adam. *An Inquiry into the Nature and Causes of the Wealth of Nations*. ed. Edwin Cannan. (London: Methuen & Co. Ltd, 1904. Library of Economics and Liberty [Online] available from <http://www.econlib.org/library/Smith/smWN.html>) Book I, Chapter IV. Section 1. Accessed February 25, 2016.

¹⁷ Smith, *Wealth of Nations*, Book I, Chapter IV. Section 13.

¹⁸ Smith, *Wealth of Nations*, Book I, Chapter IV. Section 13.

exchange what he or she has for goods that he or she has identified as valuable, goods whose end is not that of further exchange, but of fulfillment of the individual. Smith's market creates the mechanism by which Locke's moral proprietor can physically, either in possession or action, display his or her vision of the good life. However, the mere possession of goods intended to display one's conception of the good life is only relevant when the notion of the good life is unchanging. Unfortunately, consumer culture complicates the possibility of a static correlation between good life and material goods. In a culture that places tremendous value on the individual's freedom to forge a unique vision of the good life and express it through participation in the market, the very notion of the good life is susceptible to external influence(s) to which the individual may very well be blind. Achieving one's vision of the good life may prove challenging enough, but keeping with the shifting culturally acceptable vision of the good life is surely impossible for a majority of individuals. For the unhealthy aging individual, there appears to be little to no possibility of satisfying the mercurial vision of the good life generated by consumer culture, and for the unhealthy and dependent aging individual, the prospect of the achieving the good life proves to be nothing more than fantasy.

Commenting on the newly formed United States, Alexis de Tocqueville notes the ways in which autonomy manifests itself as society's primary value. The sovereignty of the people, as de Tocqueville names it, is "not hidden or sterile as it is in certain nations; it is recognized by the mores, proclaimed by the laws; it spreads freely and reaches its full consequences without obstacles."¹⁹ He explains that the value of autonomy is witnessed not only in the democratic structure of government alone, but also generally in the spirit of the people. That spirit translates

¹⁹ Tocqueville, Alexis de, Eduardo Nolla, and James T. Schleifer. *Democracy in America: Historical-critical edition of de la démocratie en Amérique*. Bilingual French-English ed. (Indianapolis: Liberty Fund, 2010) 91-2.

into the ways in which individuals conduct themselves politically as legislator-rulers who wield their power “as God rules the universe.”²⁰ While this is only an observation conditioned by the experience of a liberal democratic culture, it poignantly captures how individual liberty or autonomy was actually understood by the American people – he was witness to the theoretical claims of autonomy being practiced. Rights were virtues introduced into the political sphere for de Tocqueville – virtues believed to be emblematic of great individuals and rights without which there could be no great people.²¹ In further strengthening the moral importance of autonomy by invoking the language of rights as virtues he is able to connect the absolute right of autonomy to those practices that enable an individual to pursue the good life. Of course, those practices need the proper environment in order to be exercised, thus de Tocqueville’s rosy assessment of early American democracy. The democratic system offered the right space for living as one wished to live, for oneself by oneself, but mindful and tolerant of others. The political structure was designed to protect freedoms and enable individuals to pursue their own goals while staying at arm’s length. On its own, de Tocqueville’s vision of freedom is innocuous for an ethics of aging because his claims are not normative, so when does an emphasis on autonomy within the good life become detrimental to the aging? It does so when autonomy takes a libertarian turn, and the idea of dependency is disparaged.

Beyond the early stages of autonomy’s prominence in American culture, the late 19th century arrival of John Stuart Mill’s treatise on liberty moved autonomy into a more libertarian

²⁰ de Tocqueville, *Democracy in America*, 97.

²¹ de Tocqueville, *Democracy in America*, 389.

interpretation.²² Mill's work to connect individual liberty to wellbeing more fully established the primacy of autonomy as *the* value among American values. His beliefs on individual liberty and the autonomous nature of the person are neatly summarized: "Human nature is not a machine to be built after a model, and set to do exactly the work prescribed for it, but a tree, which requires to grow and develop itself on all sides, according to the tendency of the inward forces which make it a living thing."²³ From this it is clear that Mill proclaims individuality and one's capacity and duty to express one's self as an individual are essential human characteristics.²⁴ Mill's autonomous individual does not differ from those before him: one is naturally absolutely free to pursue his or her own good in his or her own way, so long as one does not attempt to deprive other individuals of theirs, or impede their efforts to achieve their own individually identified good(s).²⁵ Pursuing a self-legislated vision of the good life is part of Mill's understanding of

²² Mill, John Stuart, and Leonard Kahn. 2015. *On Liberty*. (Peterborough, Ontario; Tonawanda, NY: Broadview Press, 2015), 120. There is an ongoing debate about whether Mill can be classified as a libertarian. His remarks concerning the extent of a government's power over individuals are targeted toward a government that oversteps its bounds in denying the individual's pursuit of the good life. When the government takes the place of the individual and attempts to legislate that which is good for the individual the government has overstepped its bounds. It has effectively violated its very essence in having been appointed or elected by those autonomous individuals who so chose to cede limited powers to the government. Protection and defense, in line with his remarks about the extent of individual liberty, are the only legitimate reasons for government intervention in the private life of an individual. This sounds similar to modern day libertarian thought, but Mill adds a series of other cases for government intervention that go beyond the general categories of protection and defense. Those elements which have previously been determined to be detrimental to individuality in terms of an individual being able to flourish after practicing a given behavior are also under the purview of government. The modern libertarian can see moralizing, in this sense, as stifling individuality, but for Mill is a justifiable intervention under the auspices of protection of the individual. "The only things it is sought to prevent are things which have been tried and condemned from the beginning of the world until now; things which experience has shown not to be useful or suitable to any person's individuality. There must be some length of time and amount of experience, after which a moral or prudential truth may be regarded as established: and it is merely desired to prevent generation after generation from falling over the same precipice which has been fatal to their predecessors."

²³ Mill, *On Liberty*, 99.

²⁴ Mill's notion of autonomy is different than that of Kant, for example. Because this historical overview is concerned strictly with the American development of autonomy and reception of the selected thinkers, alternative notions of autonomy that are more developed in later philosophical discourse will not be addressed.

²⁵ Mill, *On Liberty*, 56.

individual liberty.

The first element of liberty pertains to an individual's conscience or "liberty of thought and feeling," meaning an "absolute freedom of opinion and sentiment on all subjects, practical or speculative, scientific, moral, or theological."²⁶ Second, liberty consists in one's ability to frame and plan one's life according to one's to-be-fulfilled character,²⁷ without impediment from other individuals. The cultivation of such individuality is the only thing that can produce a well-developed person, according to Mill. Such development "brings human beings [themselves] nearer to the best thing they can be."²⁸ Last, liberty enables individuals to unite for any purpose so long as it does not infringe on the liberty of or harm others. Living in a community that tells individuals how to live or obliges individuals to be responsible for others could be seen, through Mill's eyes, as infringements on liberty. Asking others to show special concern for certain members of the community, i.e. the aging, or worse, demanding that special concern be given, is not part of Mill's vision of autonomy. While Mill maintains that society is not founded on a contract, he affirms that "everyone who receives the protection of society owes a return for the benefit, and...that each should be bound to observe a certain line of conduct toward the rest."²⁹ Determining the obligations and limits of 'protection' and 'return for the benefit' was not necessarily a concern of Mill's, an oversight that can be linked to current opinions on social responsibility concerning dependent aging persons. Nevertheless, Mill remains particularly

²⁶ Mill, *On Liberty*, 55.

²⁷ Mill, *On Liberty*, 100. Character here refers to "a person whose desires and impulses are his own – are the expression of his own nature, as it has developed and modified by his own culture.

²⁸ Mill, *On Liberty*, 103-4.

²⁹ Mill, *On Liberty*, 114.

important because he connects freedom and the good life. Without freedom, one cannot live the good life. Without having freely established oneself as an individual, one cannot live the good life. These two ideas that emerge from Mill are important for an ethics of aging because the freedom of the aging individual is, of course, integral. No ethics should seek to undermine or deny the freedom of an individual; however, just as health is not the only indicator or condition of the good life, neither is living freely and independently. These claims will be revisited in later chapters, but it is important to note that they continue to influence modern perceptions about what it means to age well.

Life, liberty, and the pursuit of happiness were the values with which this examination began. The essential condition of freedom, protected by the founding texts of the US, develops uniquely in the American economic context. As an individual came to appreciate his or her capacity for autonomous thought and action regarding the pursuit of happiness or the good life, the market helped respond to what those self-generated visions might look like. As consumer culture evolved, the acquisition of goods became a primary source of self-expression, as Locke had suggested it should. While the relationship between the market and autonomy took shape, a newer interpretation of liberty was brought into the fold, namely libertarianism. The introduction of Mill's libertarian thought reinforced the importance of autonomy, but added the idea that the good life should be achieved on one's own without assistance from others (individuals or the government). Combining the libertarian approach to achieving the good life with the material good life provided by the market, it becomes clear that the social imageries of aging are complex obstacles for an ethics of aging to overcome.

Autonomy And the Good Life In Consumer Culture

As the primary value of America, autonomy went beyond the political arena and permeated every aspect of culture. One such intersection is that of the creation and practices of consumer culture. The manner in which autonomy presents itself in consumer culture can be traced back to the distinction between Locke and Smith. The former claimed that the possession and display of goods and conduct (understood as a possession) embodied one's notion of the good life, while the latter addressed the value one ascribes to goods and the means necessary for acquiring and maintain those goods even if the symbolic goods changed over time. Individuals were free to consume those things that best represented their vision of the good life. Economic participation, both as producer and consumer, made the pursuit of the good a more tangible endeavor to yield a comprehensive vision of the good life. Theories of consumer culture pick up on the claims of Locke and Smith and highlight those dual roles of producer and consumer. As Smith explained, the increase in the social value of goods being bought and sold on the market in the form of consumer products provided further motivation for individuals to work in order to facilitate the acquisition of those things that would satisfy their vision of the good life. This cyclical relationship was witnessed by de Tocqueville.

In a relatively short chapter of *Democracy in America* entitled "Of the Taste for Material Wellbeing," de Tocqueville remarks that passion for material wellbeing is a general disposition of all Americans. "The concern to satisfy the slightest needs of the body and to provide for the smallest conveniences of life"³⁰ is universally experienced, held, and acted upon. Pursuit of the goods requisite to wellbeing found Americans "tormented constantly by a vague fear of not

³⁰ de Tocqueville, *Democracy in America*, 931.

having chosen the shortest road that can lead to it [wellbeing].”³¹ This observation reveals that even from its earliest years, American culture was a consumer culture that partially located the good life in the acquisition of material possessions (the other part belonged to individual liberty). De Tocqueville summarizes his observations of the early manifestations of American consumer culture:

The man who has confined his heart solely to the pursuit of the goods of this world is always in a hurry, for he has only a limited time to find them, to take hold of them and to enjoy them. The memory of the brevity of life goads him constantly. Apart from the goods that he possesses, at every instant he imagines a thousand others that death will prevent him from tasting if he does not hurry. This thought fills him with uneasiness, fears, and regrets, and keeps his soul in a kind of constant trepidation that leads him to change plans and places at every moment.³²

He believes that this spirit of satisfying wellbeing with diverse and evolving material possessions is part of a democratic society in which there exist different socioeconomic strata that are not fixed. This spirit enables hope and a perceived ease of access to the good life for those of lower social strata and reinforces the need to persist in acquiring goods to keep pace with those of upper social classes.³³ The notion that wellbeing can be and has been commodified leads to a more comprehensive discussion of consumer culture and its influence on both identity and the good life.

What de Tocqueville and others had observed regarding the impact of autonomy in the market on individual identity and moral worth recently became its own field of study in the form of Consumer Culture Theory (CCT). Though the recognition that consumer culture has very

³¹ de Tocqueville, *Democracy in America*, 943.

³² de Tocqueville, *Democracy in America*, 945-6.

³³ de Tocqueville, *Democracy in America*, 933.

noticeable effects on the thoughts and behavior can be traced to the work of Karl Marx.³⁴ Eric J. Arnould and Craig J. Thompson, the unofficial founders of CCT, offered this 2005 definition of consumer culture: “[consumer culture] denotes a social arrangement in which the relations between lived culture and social resources, and between meaningful ways of life and the symbolic and material resources on which they depend, are mediated through markets.”³⁵ Consumer culture goes beyond a study of market relations between supply and demand. Instead, consumer culture presents a complex framework for addressing how consumed goods assume their respective meanings both socially and for the individual subject. The goods marketed and exchanged in a consumer culture are not limited to serving their designed function; they are integral or even necessary in aiding individuals in their pursuit of the good life. In other words, consumer culture does not only have economic ramifications, but also has profound psychological and moral influences on its subjects. “Consumption revolves around the acquisition of things to confirm, display, accent, mask, and imagine who we are and whom we wish to be,” which can “instrumentally display social status, evoke ethnicity, or exhibit gender” and can “also be an unexpressed process of self-definition and collective identification.”³⁶

Consumer culture provides a powerful and ubiquitous medium through which identity and wellbeing are communicated, interpreted, and realized. In psychology, identity refers to the subjective concept to which one holds oneself – it is deeply personal, emerging from and

³⁴ See Karl Marx, *A Contribution to the Critique of Political Economy (1859)*, in which Marx outlines the ill-effects of Smith’s *Wealth of Nations* on capitalistic societies regarding the objectification of the worker, and, *Capital: Critique of Capital Economy (1867)*, in which the critique of commodity fetishism and the damaging effects of the market on the recognition of human agency in the capitalistic society are addressed.

³⁵ Arnould, Eric J, and Craig J Thompson. 2005. Consumer Culture Theory (CCT): Twenty years of research. *Journal of Consumer Research* 31 (4): 868-82. doi:10.1086/426626.

³⁶ Mullins, Paul R. 2011. *The Archaeology of Consumer Culture*. (Gainesville: University Press of Florida, 2011), 2.

cultivated within the subject, and it is inclusive of the multitude of modes of self-representation that an individual displays in response to various social roles.³⁷ Psychologists describe wellbeing as composed of both the traditional bodily (and mental) health factors outlined in Chapter One and the more amorphous idea of happiness or subjective wellbeing, which concerns “life satisfaction, a cognitive evaluation of life over time, but also the frequent experience of positive emotions and the absence of negative emotions.”³⁸ A demonstrative example of consumer culture’s influence on identity and subjective wellbeing is that of body image. This will be taken up below, but it is worth noting that the ideal body image communicated through consumer culture is arguably the most comprehensively influential message conveyed to the Third Ager seeking to live well. How modern consumer culture became capable of influencing the individual in such profound ways requires explanation going beyond the seeds that were planted by Locke and Smith, and whose early fruits were observed by de Tocqueville.

While the influence of consumer culture can be interpreted in a number of ways, Mike Featherstone, a British sociologist, limits his assessment to two. He first explains that the growth of consumer culture, commensurate with the expansion of modern capitalist economies, has led to a tremendous rise in the accumulation of a “material culture”³⁹ expressed in various consumer goods. Consumer culture then not only signals the general growth of the modern economy but also points to the type of materialism about which Smith spoke – namely that materialism is intrinsically linked to the freedom one has to produce and consume so modes of self-expression.

³⁷ Dittmar, Helga. *Consumer Culture, Identity, and Wellbeing*. (New York, NY: Psychology Press, 2008), 8.

³⁸ Dittmar, *Consumer Culture*, 9.

³⁹ Featherstone, Mike. *Consumer Culture and Postmodernism*. Theory, Culture and Society. (London; Newbury Park: Sage, 1991), 13.

However, this seemingly innocuous reciprocal relationship can precipitate “ideological manipulation and seductive containment of the population from some alternative set of ‘better’ social relations,”⁴⁰ which transforms the appeal of discovering the good life in the market into a power capable of shaping the very terms for wellbeing. This manipulative power becomes the substance of Featherstone’s second theory of culture where consumer culture represents the “zero sum game in which satisfaction and status depend upon displaying and sustaining differences within conditions of inflation.”⁴¹ Both the expansion of materialism and the ability of the market to become the source of self-identity and wellbeing are particularly relevant to the social imageries of the good life and for the Third Age. If it is fair to presume one’s history of participating in and being affected by the dominant consumer culture, then the aging person may very well be faced with a far more arduous task given the power of consumer culture. The meaning and wellbeing sought by the Third Ager may well be contingent upon factors extrinsic to the individual, undermining the very autonomy valued in American culture and upon which consumer culture is built. Faced with an increasing amount of consumer goods and experiences that are billed as paths to or representations of integral elements of the good life, the aging individual is faced with the realization that he or she is the product of Locke’s moral proprietor and Smith’s laborer. Negotiating consumerism and materialism must be a task of an ethics of aging. One of the ways in which consumer culture has come to be the primary source of mediating the good life is through its commodification of self-image.

Capable of constructing and marketing ideal images of the self to be attained through the

⁴⁰ Featherstone, *Consumer Culture and Postmodernism*, 13.

⁴¹ Featherstone, *Consumer Culture and Postmodernism*, 13.

consumption, either by purchase for specific use or for possession alone, consumer culture represents a powerful force in shaping what it means to live the good life. It has become a subconscious requirement to possess the so-called 'right' thing with the hope of it providing certain psychological benefits such as "popularity, identity, and happiness."⁴² As one of the most demonstrable modes of self-creation, consumption enables individuals to achieve or attain an identity rather than develop one – the individual can purchase the ideal self while knowing full well that he or she is not and almost cannot be that ideal. Helga Dittmar notes that individuals are not always aware of how consumer culture influences their vision(s) of the self, but summarizes the formula as such: the individual has an image of the self now, is subjected (directly and indirectly) to the symbolic meanings of consumer goods, and then arrives at a newly envisioned image of how it is that the individual wishes to be – a process that begins in childhood and only further entrenches itself in the psyche of the person as he or she ages.⁴³ One can attain happiness by acquiring possessing and/or using that which consumer culture has marketed as ideal or requisite for the material good life. Part of the liberal tradition assumes the value of being an individual, and being able to consume helps one forge an individual identity, enabling one to stand out from the rest – to have and to hold one's vision of the good life. In other words, the goods marketed convey a very simple, yet powerful, message "buy this and it will enhance your sense of self-worth; indeed, buy 'because you are worth it!'"⁴⁴ The goods and their meaning(s), by nature of presenting themselves as capable of enabling one to consume the good life, provide the consumer the power to take control of the development of the self. By offering individuals

⁴² Dittmar, *Consumer Culture*, 1.

⁴³ Dittmar, *Consumer Culture*, 13.

⁴⁴ Dittmar, *Consumer Culture*, 22-23.

the ability to create, shape, and alter self-identity, the market reinforces the value placed on individual liberty outlined above. Not only is the individual given the opportunity to participate in the economy by producing goods to be consumed, but also by having the freedom to acquire the goods necessary to satisfy the individual's self-identity and notion of wellbeing.

One of the ways in which the commodification of self-image has taken place lies at the intersection of identity and wellbeing, namely body image. Women and men are both subject to the influence of consumer culture when it comes to sociocultural body ideals. Aging persons in particular are subjected to an array of ideal images, some of which are mediated through an approach to medicine that wishes to mask or correct the physical signs of aging. As was shown in Chapter One, the healthy functioning body is the one best suited for living the good life; therefore, the appearance of functioning can connote social value and the image of living well. Thinness is marketed as an ideal type for women and muscularity an ideal type for men. Female models have historically been portrayed as the ideal of thinness toward which all women should strive despite the potential health risks of being too thin.⁴⁵ Men are presented with a similarly unattainable ideal image of the well-toned upper body resembling a V-shape. These images abound in popular media and are filtered all the way down to children's toys including dolls and action figures.⁴⁶ Sociocultural theorists argue that when presented with such images, "individuals come to feel bad about their bodies because they are exposed to unrealistic body ideals which they then feel pressured to achieve."⁴⁷ Clearly the symbolic value of these images goes much

⁴⁵ Dittmar, *Consumer Culture*, 13.

⁴⁶ This points to another issue, the gender typing of toys marketed toward children, which will not be addressed here.

⁴⁷ Dittmar, *Consumer Culture*, 125.

deeper than the desire to be *healthier*. The ideal body, argues Dittmar, transcends notions or images of physical health, possessing a symbolic value that conveys “being in control, life satisfaction, happiness, career success, or having interesting and fulfilling relationships.”⁴⁸ Ideal body image, understood as a consumer good capable of communicating much more than physical health, stresses the belief that the body’s role in achieving and displaying self-identity is paramount. Aging persons seeking to re-self-identify and pursue the good life as they transition are bombarded with unattainable ideal images. The free market and consumer culture respond to the aging person’s needs to achieve those ideals through the cosmetics industry.

Defining the cosmetics industry is much more complicated than it may seem. There are consumer cosmetic products such as creams, lotions, hair dyes, and make-up that comprise the more traditional retail-consumer sector of the industry with which many are familiar. Moving beyond these ordinary products available to the masses are the more exclusive cosmeceuticals. Distorting the line between non-prescription and prescription drug, cosmeceuticals can address any of the following:

the product has pharmaceutical activity and can be used on normal or near-normal skin; the product should have a defined benefit for minor skin disorders; and as the skin disorder is mild the product should have a very low-risk profile.⁴⁹

The products,⁵⁰ such as those sold by Dermalogica® Perricone MD and Neutrogena®, combine

⁴⁸ Dittmar, *Consumer Culture*, 14.

⁴⁹ Bert Jan Vermeer. “Definition” in *Cosmeceuticals and Active Cosmetics*, eds. Peter Elsner and Howard I. Maibach. (New York, NY: Marcel Dekker, 2000), 11.

⁵⁰ Commonly used skin cosmeceuticals are: alpha hydroxy acid, botanicals, depigmenting agents, exfoliants, moisturizers, topical peptides, retinoids, and antioxidants. Nikita Wanjari and Jyostsna Waghmare. “A Review of Latest Trend of Cosmetics-Cosmeceuticals” *International Journal of Pharma Research & Review*, May 2015; 4(5):45-51. Retinol (Vitamin A), for example, is a primary ingredient in various serums and moisturizers advertised as capable of repairing wrinkles and smoothing skin. Many antioxidant products are described as neutralizing free radicals, a contributing factor to cellular impairment and potentially the development of cancers. A botanical such as

the ease-of-access of the traditional products and the scientifically researched and proven effects of medicinal/pharmaceutical drugs. A third sector of the cosmetics industry is cosmetic surgery or medicine proper (so as to distinguish it from the gray area occupied by cosmeceuticals). Cosmetic surgery includes any medical intervention, where medical means administered by a licensed medical practitioner doctor or nurse, for aesthetic (beautification) not reconstructive (post-injury or resulting from an underlying pathology) purposes. These can include invasive procedures of varying degrees such as facelifts, liposuction, brow lift, and rhinoplasty⁵¹ where the purpose is aesthetic augmentation or ideal body image rather than improving physical functioning. Arguing in line with the medical ethicists who claim that aging is a disease to be overcome, plastic surgeons and other medical professionals involved in cosmetic enhancement respond to the “transitory cultural norms of beauty” that are “sufficient cause of surgical improvement,”⁵² making cosmetic surgery capable of always transcending age.⁵³ Cosmetic surgery, the most extreme of the three types of cosmetic products discussed above, presents the most interesting case regarding the aging person, self-identify, and ideal body image in consumer culture.

Dittmar argues that ideal body image is integral to the individual’s creation of self-identity from early childhood, and that that image is embedded within various cultural norms that

green tea extract is believed to have effects similar to that of an antioxidant. Sederma, a topical peptide, has demonstrated an ability to improve wrinkles.

⁵¹ Parker, Rhian. 2010. *Women, Doctors and Cosmetic Surgery: Negotiating the 'normal' body*. (New York: Palgrave Macmillan, 2010), 3.

⁵² Davis, Kathy. *Reshaping the Female Body: The dilemma of cosmetic surgery*. Hoboken: Taylor and Francis, 2013), 34.

⁵³ Davis, *Reshaping*, 34.

connect to the good life. Margaret Gullette describes an “inside/outside binary”⁵⁴ in which the aging person tries to fix how he or she is feeling (the inside) by augmenting the appearance (the outside). Given what the aging person is told about the good life from a medical perspective, it makes sense that aging persons would attempt to mask their physical or mental decline in the hopes of feeling better and being more socially appealing. The appeal achieved by the aging person who successfully masks less than optimal health is two-fold: the general personal satisfaction of looking and feeling better, and the expectation that one’s looking better brings about broader social acceptance (i.e. in the workplace – a topic to be explored below). Although the personal dissatisfaction experienced in aging “is created and exacerbated by a billion-dollar American commerce in aging that harps on women’s and men’s imperfections and ties them to growing older,”⁵⁵ culture’s role in self-identity dates back to Aristotle. In *De Physiognomia*, he explores the ‘science’ of physiognomy which established a connection between the outward, specifically facial, appearance of the individual and his or her inner self, soul, or character. “The face” explains Jane Northrop, “became the conveyer of symbolic meaning imbued with moral significance,”⁵⁶ connecting beauty with goodness and ugliness with the bad. This association continued through the 19th and into the early 20th centuries, particularly demonstrated by an increase in facial modification as a means of conforming to “the dominant aesthetic ideal.”⁵⁷

While modern society does not necessarily maintain the views of 19th century cosmetic surgery,

⁵⁴ Gullette, Margaret Morganroth. *Agewise: Fighting the new ageism in America*. Chicago: University of Chicago Press, 2013), 105.

⁵⁵ Gullette, *Agewise*, 105.

⁵⁶ Jane Megan Northrop. *Reflecting on Cosmetic Surgery: Body Image, Shame, and Narcissism*. (New York, NY: Routledge, 2012), 15.

⁵⁷ Northrop, *Reflecting on Cosmetic Surgery*, 18.

the notion of conforming to social ideals remains. The 20th century saw the evolution of cosmetic surgery in a thriving consumer culture:

Cosmetic surgeons progressively medicalized physical appearance by reclassifying the extremes of what had once been considered normal into deviations pathologized as defects or deformity. Such imperfections came to include any physical feature which caused feelings of inferiority or diminished life chances. The inferiority complex provided compelling justification for cosmetic surgeons and significantly impacted how doctors and their patients reached agreement prior to proceeding with surgery. By emphasizing the social, economic, and psychological aspects of appearance, surgeons began to share the diagnostic role with their patients, embracing their subjective evaluations in determining the actuality of deformity and the surgical corrective required.⁵⁸

For the aging person who wishes to maintain his or her sense of identity and project the ideal image currently in vogue, cosmetic surgery becomes a consumer good packaged as a medicinal therapy. Given the history of physiognomy in cosmetic surgery the aging person can come to view plastic surgery as integral to one's pursuit of the good life.

Cosmetic surgery witnessed a 274% increase between 1997 and 2014 according to the American Society for Aesthetic Plastic Surgery; a majority of those procedures were marketed to and performed on women.⁵⁹ The study conducted by Sammy Sinno et al examined online marketing of plastic surgery in the US revealing that of the researched images “3989 (94.1%) were pictures of female patients or models, 212 (5.0%) were pictures of male patients or models, and 38 (0.9%) were pictures of a female and male model together” and that only 22% of the websites consulted contained a male-specific services section.⁶⁰ While an increasing number of

⁵⁸ Northrop, *Reflecting on Cosmetic Surgery*, 23-4.

⁵⁹ Sammy Sinno, Gretl Lam, Nicholas D. Brownstone, Douglas S. Steinbrech. “An Assessment of Gender Differences in Plastic Surgery Patient Education and Information in the United States: Are We Neglecting Our Male Patients?” *Aesthetic Surgery Journal* 36 (2016): 107-110. Accessed March 7, 2016. DOI: <http://dx.doi.org/10.1093/asj/sjv100>.

⁶⁰ Sinno, “Assessment,” 107-110.

men are being introduced to and electing for cosmetic surgery, women remain the primary target of plastic surgeons. In a study conducted by Dr. Rhian Parker, women reported that cosmetic surgery was not a matter of choice but that of necessity. Reasons for going through with cosmetic surgery were grouped into three categories: a long-standing problem, body changes, and aging.⁶¹ The first group of reasons addressed image issues that the women have always had, i.e. problems with their phenotype. The second set of reasons, body changes, referred to pregnancy(ies), weight gain/loss, or a desire to reclaim their one's old body. Lastly, the aging-related reasons were psychological and physical – the image in the mirror did not reflect how one felt. The idea that the aging body alone was some sort of disappointment to the individual suggests that the 'aging as disease' argument holds enough popular appeal that it only takes the image, or perhaps thought of an aging body, to motivate cosmetic surgery. The significance of the physical appearance of an aging body as reason for undergoing cosmetic surgery cannot be overstated.

A treatment that is as nebulous as cosmeceuticals themselves is that of hormone therapy. It is favored by aging persons who wish to mitigate the physical and psychological effects of aging without the physicality of cosmetic surgeries. Near the end of the 20th century, billions of dollars were spent on the promises of hormone therapy, human growth hormone in particular,⁶² to no avail. Yet the failure of HGH and other hormone therapies has not stopped the anti-aging industry from pursuing today's most promising elixir, telomerase.⁶³ In short, telomerase has been

⁶¹ Parker, *Women, Doctors, and Cosmetic Surgery*, 75.

⁶² Holstein, *Ethics Aging and Society*, 91-92.

⁶³ In short, telomeres, the ends of chromosomes, shorten over time. When the telomeres disappear, the particular cell is no longer able to divide. Without the ability to divide the cell will be unable to repair or replace itself. Therapies aimed at increasing telomerase, the enzyme responsible for the creation of telomeres, can slow the process of

shown to have the potential to slow or reverse the process of aging by on the cellular level via blood transfusion from a younger person.⁶⁴ Such products marketed as capable of reversing or mitigating the aesthetic effects of aging continue to benefit from exponential growth. It is impossible to quantify the number of individual cosmeceuticals that purport to retard the visual signs of aging, but suffice it to say that the billions of dollars spent on advertising in this market sector continue to find an attentive audience. When the promised effects are not realized, the users react negatively,⁶⁵ but there is no indication that the anti-aging division within the cosmetics industry is slowing down. Clearly the quest for the good life in aging remains inextricably linked to the ‘aging as disease’ school of thought and is emboldened by consumer culture. That culture generates the notion that consuming itself is capable of making one happy, and when combined with anti-aging narratives, evolves into the compelling idea that consuming anti-aging products is an appropriate and readily available straightforward path to the good life.

Consumption then becomes a method for attaining the good life both in and of itself and in the particular forms of anti-aging products. Consuming or being able to consume provides an individual with a socially acceptable identity that remains responsive to shifting socio-cultural trends. In this regard, a satisfactory self-identity is contingent upon one’s being able to respond to those shifting goods. Being able to adapt to transitory norms requires the financial means,

cellular aging. For a full description of the science behind telomerase in the aging and anti-aging medicine, see: Peter J. Horsnby. 2007. “Telomerase and the Aging Process” *Experimental gerontology*. 42(7):575-581. doi:10.1016/j.exger.2007.03.007.

⁶⁴ Alice Park. “The Science of Youth” in *Secrets of Living Longer*. ed Nancy Gibbs (New York, NY: Time Inc. Books, 2015), 13-15.

⁶⁵ In June 2014, L’Oréal SA settled a court case that argued L’Oréal had made “false and unsubstantiated claims that its Lancome Genifique Paris Youth Code skin-care products involved anti-aging benefits by targeting user’s genes.” Accessed February 4, 2016, <http://www.bloomberg.com/news/articles/2014-06-30/l-oreal-settles-u-s-claims-on-anti-aging-cosmetics-ads>.

which many aging people do not have, and ironically may place some aging persons in a situation that has them placing their anti-aging needs above their real health needs. However, being able to respond to the changing norms also requires that one is healthy enough to deal with the unforeseeable consequences of using cosmeceuticals given their lack of regulation, healthy enough to undergo cosmetic surgeries, healthy enough to experiment with telomerase. Once again it is the functioning body that is needed in order to maintain the good life; here, however, it is not necessary the most important element, only part of aging well. Aging well in a consumer culture means consuming those products that are synonymous with youth or claim to make one more youthful in appearance. However, what is sacrificed in the cycle of consumption is the individual's authentic vision of the good life – no longer is the good life being defined on the individual's terms; instead the good life is mediated through goods determined to be requisite for the actualization of the good life by society. In this case, the individual will never come to actualizing the good life given the ephemeral nature of the value bestowed upon consumer goods regarding one's satisfaction. However, there has been more to aging well in the modern American context than what consumer culture offers. Public policies have attempted to secure wellbeing for the aging that was not only determined in economic (read: consumer-producer) terms.

During the 20th century, a time in which consumer culture would experience a rapid expansion, the federal government embraced a different approach to aging, focusing on 'responsible individualism,' but also declaring care for the aging a federal responsibility. The policies enacted reflect a disconnect between the good life in aging as contingent upon producing or consuming promoted within consumer culture and a political vision that the success of the

country was bound to the success of the aging. The ‘responsible individualism’ called upon all Americans to recognize shared communal bonds and that those bonds do not disappear once an individual leaves the work force or no longer meets cultural beauty ideals. Most importantly, the government policies concerning the aging population were a counter-narrative to the belief that the good life could be reduced to functional health, and that that good life should be made available to all aging persons regardless of class, race, and gender.

Autonomy And American Public Policy

As has been demonstrated above, the good life in America has always been bound to individual liberty or autonomy whether as a political or cultural value. In consumer culture the aging individual is inclined to exercise personal freedom by way of responding to socially created ideal image norms or in acquiring goods, both of which are perceived to be demonstrative of the good life. Commodifying the good life, however, actually limits freedom by reducing its expression and fulfillment to one medium, namely consumption. The inherently inequitable move only exacerbates pre-existing impediments to achieving the good life given the socioeconomic diversity of the aging population. What commodification does then is cause aging persons to pursue happiness-in-having and lose sight of more profound and perhaps more authentic elements of the good life. While the problem of commodification of the good life does not universally plague the aging population given the socioeconomic diversity of individuals in the Third Age, commodification of the good life is part of the American cultural ethos that does transcend socioeconomic strata. The political discourse of the 20th century offers a view of aging well that transcends consumer culture in many regards. Starting with the New Deal the economic needs of aging persons were brought into public view. Economic needs were and still are linked

to health care needs, thus the latter also became a subject of public policy in order to prevent a person's health from being contingent upon market forces. The health of the aging, as outlined in Depression and Post-Depression era policies, was described as a basic right; support systems were to address real-life needs – they did not focus on superficial needs like youthfulness and beauty. The policies were to be supported, financially and otherwise, by all members of society. Still, the support provided to aging persons was not intended to dismiss the value of independence vis-à-vis personal responsibility for self-care. Independence remained important in the crafting of the welfare policies designed for the aging, but the emphasis on who was responsible for bringing about the good life changed: American culture is one that supports all individuals and helps them to move toward their own vision of the good life, never claiming that having to rely on the help of society or the government diminishes the value of the person.

The myriad effects of the Great Depression can still be felt today, and in many ways, are more overtly present than we might recognize. A time that called for a reassessment of national values and corollary policies and practices, the Depression asked that Americans push their “dreams of boundless prosperity and the images of pioneers carving out a niche in the frontier”⁶⁶ aside in the face of harsh economic realities. The recovery begun by Hoover did not tear down capitalism, nor did it attempt to change the systemic problems that contributed to the implosion of the economy. Hoover assumed that the proverbial ship would right itself so long as the citizens practiced a “responsible individualism.”⁶⁷ History shows that the economy did not respond to such a thin solution to an incredibly complex problem, and the man who is associated

⁶⁶ Achenbaum, W. Andrew. *Shades of Gray: Old Age, American Values, and Federal Policies since 1920*. Little, Brown Series on Gerontology. (Boston, MA: Little, Brown, 1983), 31.

⁶⁷ Achenbaum, *Shades of Gray*, 31.

with saving the economy and perhaps the United States, Franklin Delano Roosevelt, was elected after campaigning to make dramatic improvements in the so-called first 100 days. The New Deal was an economic and a socio-cultural policy aimed correcting the past and augmenting the future. The specific initiatives of the New Deal understood the “limits of self-reliance” and accepted “the value of interest-group liberalism,” which led to the federal government promoting the general welfare and economic security of all citizens.⁶⁸ Those citizens who had suffered the most with the least amount of time to recover became a primary focus of New Deal economic policy, thus the rescue of aging persons, whom faced insecurity through no fault of their own, would be a priority.

The Social Security Act of 1935 (SSA) was the first step in addressing the complex needs of the aging population in the US. Intended for those who had reached the age of 65 as of January 1, 1942, the account to be drawn upon was overseen by the federal government but left to the states regarding distribution amounts. Despite its founding on an incrementalist⁶⁹ belief that the type of protection could be changed minimally here and there with the possibility of major overhaul, the policy proclaimed that the federal government had a duty to “deal with the elderly’s plight as a vital aspect of ‘general welfare.’”⁷⁰ However, the aging, identified as elderly given the time period’s standards of longevity and mortality, was not as inclusive a category of 65-year olds as it appeared. SSA described the aging as white individuals who had previously

⁶⁸ Achenbaum, *Shades of Gray*, 34.

⁶⁹ Achenbaum, *Shades of Gray*, 40. Incrementalism is explained by Achenbaum in this way: “They [the New Deal policymakers] hoped to prove the validity of certain philosophical principles within carefully prescribed parameters and to demonstrate the viability of their programs with sharply limited target populations before they attempted to address the poverty problem in all of its ramifications. In other words, they deliberately left the situation fluid.”

⁷⁰ Achenbaum, *Shades of Gray*, 40.

labored in particular production sectors: “Title II [of the Social Security Act] did not initially apply to farm workers, government employees, military personnel, or clergy, among others.”⁷¹ SSA established a threshold of minimum contribution to the aged poor and ensured that an equitable return on contribution was offered to everyone (who met the specifications of SSA) but the policy-writers “assumed that people would resume making provisions for their old age and that corporate involvement in welfare capitalism would be expanded.”⁷² Social Security taxes that were instituted then functioned as they do now with the wealthier members of society paying larger amounts so as to enable a wider and more equitable distribution of funds to those most in need. Regardless of whether the relevant taxes directly aided individuals or provided financial relief to the larger family unit of the aging person, SSA was designed to ease the transition from working life to retired life for society writ large. However, it was in the interpretation of the timing of that transition that debate arose. “Provisions of the old-age insurance program were not used to initiate a compulsory retirement scheme at the national level,”⁷³ but it was partially received in that way for at least two reasons. First, mandatory retirement programs in the private sector emerged to complement SSA. Second, SSA dollars were allocated differently to persons who were able to continue to work after age 65, a disproportionate benefit created by the mandatory retirement movement. While Social Security continued to be debated, amended, and augmented, Roosevelt continued his push for a vision of democratic government that genuinely

⁷¹ Achenbaum, *Shades of Gray*, 41. “Blacks and Mexican-Americans were especially penalized by this ruling [a caveat regarding different types of employment groups], because of their heavy concentration in agricultural occupations. Policymakers clearly assumed that coverage would someday be universal. Various segments of the aged population shared this hope. But expectation is not entitlement.”

⁷² Achenbaum, *Shades of Gray*, 43.

⁷³ Achenbaum, *Shades of Gray*, 46.

cared for the wellbeing and happiness of each and every citizen.⁷⁴ After the Second World War there was a marked shift in the social policies regarding aging persons; however, an increase in spending did not produce the expected commensurate decrease in poverty among the aging.⁷⁵ Despite this, the policy arrangements were left mostly unchanged and instead private insurance companies marketed “old-age insurance” to aging persons as a complement to SSA. The political concern for the wellbeing of the aging did not dissipate and reached an apex with the children of the Great Depression who worked to establish the ‘Great Society.’

Lyndon Johnson adopted Roosevelt’s moral vision by making the war on poverty the cornerstone of the ‘Great Society.’ The aging members of American society became the primary focus of this war insofar as their demonstrated need and vulnerability exceeded that of many other groups. One of the primary ways in which the aging person could experience wellbeing is through overall health, thus a supplement to Social Security with the particular focus on health care access and insurance for aging members of society was implemented during this time.

Public Law 98-97, Medicare, consisted of two parts: A and B. Part A was, and is, an insurance plan granted to those who qualified for Social Security benefits. Part B, a voluntary supplement, functioned to defray the cost of physician visits and diagnostics, much like a traditional private health insurance plan. Still, as helpful as Medicare was (and is) for those over 65, it did not completely satisfy Roosevelt’s wish to protect the welfare of all citizens or Johnson’s war on poverty. Thus, another plan materialized into a policy that addressed medical needs of the aging and the poor regardless of age, namely Medicaid. An additional contribution of the ‘Great Society’ era was the passage of the Older Americans Act (OAA) in 1965 that

⁷⁴ Achenbaum, *Shades of Gray*, 51.

⁷⁵ Achenbaum, *Shades of Gray*, 64.

ensured the aging population would be a focus of policy-making on the federal and state levels,⁷⁶ while working to ensure “adequate incomes and health services on the one hand, and independence and creative leisure on the other without intimating that such goals were incompatible.”⁷⁷ OAA represents the first policy attempt to outline a vision of the good life for aging persons. It highlights the importance of having a sufficient amount of money and access to health care, both of which have already been shown to be requisite needs in achieving the good life in America, and also moves the conversation forward by addressing the quality of the aging person’s life. This initial attempt at articulating the good life for the aging marked a shift in political concern that revived Roosevelt’s moral vision for society. No longer were the aging just a group who received special benefits to ensure their health and ability to take care of themselves financially; instead they were a group whose social involvement was the responsibility of the government in part but also of the community. OAA represents a policy attempt to overturn previously held beliefs about what the good life in aging required: the aging person was not obliged to serve others in order to live well; the aging person did not receive benefits only because he or she was productive. An early vision it may be, the groundwork laid by OAA is of great import.

Unfortunately, the progress of OAA and many other social policies was hampered by the political and social upheaval of the Vietnam era, and by the 1980s America witnessed a shift in policies that did more to radically change the cultural opinions of the aging than previous eras. The election of Ronald Reagan and the consequent revisions made to social welfare policy not only adjusted the amount of government assistance offered to aging persons, but also affected

⁷⁶ Achenbaum, *Shades of Gray*, 93-4.

⁷⁷ Achenbaum, *Shades of Gray*, 101.

social perceptions of the aging. There was never universal agreement on the role of government and society in aiding the aging in their quest for the good life, but there certainly was enough popular support to sustain Roosevelt's and Johnson's morally charged political and social visions through the 1970s. Reagan's inaugural address identified government as part of the problem and not the solution to the country's economic problems, but to be clear, he did not attack Social Security or Medicare directly. His effort to balance the federal budget led to a bipartisan compromise that "slightly raised the retirement age, boosted payroll taxes, and taxed the benefits of high-end recipients for the first time."⁷⁸ Yet, there was political tumult in response to Reagan's unwillingness to shrink social welfare programs like Social Security, and the budget was not passed. Reagan himself believed that the welfare policies contributed to poverty, but he understood that cuts in those programs would be costly politically.⁷⁹ By the end of Reagan's terms, the negative perception of the social welfare benefits afforded to the aging and the aging themselves became a more pronounced part of the public discourse, making the expansion and comprehensive realization of OAA near impossible. The initiatives that worked to secure the health and financial wellbeing of aging persons mitigated the effects of social and political marginalization for the aging.

Democratic reforms to social welfare policies took on their own tenor during the presidency of William Jefferson Clinton. In one of his first entitlement program-oriented addresses in 1993, Clinton praised the societal benefit of the contributory entitlement programs,

⁷⁸ Miller Center of Public Affairs, University of Virginia. "Ronald Reagan." <http://millercenter.org/president/biography/reagan-domestic-affairs>. Accessed January 23, 2016.

⁷⁹ Ronald Reagan "Radio Address to the Nation on Welfare Reform." Speech, Washington, DC, February 15, 1986. *The American Presidency Project*, Accessed February 11, 2016, <http://www.presidency.ucsb.edu/ws/?pid=36875>.

Social Security and Medicare, exclaiming,

Because of these programs, we are a healthier people. We are a more unified country. We treat our elderly with greater dignity by having allowed (*sic*) them to earn a decent retirement and to maintain a middle-class standard of living, independent of whatever their children are required to do, and to make them more independent over the long run.⁸⁰

Social Security and Medicare in his view, like Johnson before him, were responsible for lowering poverty among the aging, and worked to improve the overall welfare of society.

However, Clinton was faced with a budget-deficit problem that required certain changes to the way in which the programs were structured regarding acquisition and distribution of funds. It was Medicare and Medicaid that presented the most problems given the exponential increases in cost per capita for health care during the 1990s, and Clinton knew that the health of the aging population was inextricably linked to the welfare of society. His popular ‘putting people first’ mentality shone through in his remarks concerning the aging in that he reminded the public that the recipients of the welfare benefits were individuals whose dignity had to be honored as part of what it meant to be American. “[Social Security] reflects some of our deepest values,” he remarked in 1998; “the duties we owe to our parents, the duties we owe to each other when we’re differently situated in life, the duties we owe to our children and our grandchildren.”⁸¹ He attempted to reinvigorate the moral vision of Roosevelt and the idea of the good life in aging first outlined in OAA by reminding society of its interdependence and the reciprocal duties all

⁸⁰ William Clinton. “Remarks by the President in Addressing the Future of Entitlements Conference.” Speech, Bryn Mawr, PA. December, 13, 1993. Accessed February 11, 2016, <https://www.ssa.gov/history/clntstmts.html#conf>.

⁸¹ William Clinton. “Remarks by the President on Social Security.” Speech, Washington, DC. February 9, 1998. Accessed February 11, 2016, <https://www.ssa.gov/history/clntstmts.html#conf>.

citizens have in taking care of one another, especially cross-generationally.⁸² On an almost monthly basis throughout his presidency, Clinton addressed the importance of Social Security and Medicare in protecting the nation, but that protection came at too high a cost for the taxpayers. In order to maintain these entitlements, taxes were raised, not cut, despite there being a sizeable surplus in 1999.⁸³

Today, Medicare has been amended to include a Part D for prescription drugs, and the Older Americans Act continues to be reauthorized without much progress materializing from its renewal(s). In 2015, the US Senate focused on the revitalization of community senior centers, an important topic to be explored in chapter five, but there remains legislative work to be done as the welfare of aging Americans remains a perennial concern for policy-makers.⁸⁴ Social Security, Medicare, and Medicaid (insofar as it addresses the older poor), continue to be the subjects of political conversation, yet there is reluctance to suggest cuts to those programs given the political power of the aging voting demographic among other practical concerns. However, the idea that the end of these programs reemerges for public discussion during every election cycle reveals that there remains a cultural disconnect from the very essence of the policies, namely that the government should not be responsible for taking care of the needs of particular individuals. The tension that exists between social and civic responsibility and the value of autonomy in America

⁸² Clinton, "Social Security." "This fiscal crisis in Social Security affects every generation. We now know that the Social Security trust fund is fine for another few decades. But if it gets in trouble and we don't deal with it, then it not only affects the generation of the baby boomers and whether they'll have enough to live on when they retire, it raises the question of whether they will have enough to live on by unfairly burdening their children and, therefore, unfairly burdening their children's ability to raise their grandchildren. That would be unconscionable, especially since, if you move now, we can do less and have a bigger impact, especially since we now have the budget surplus."

⁸³ According to the Office of Management and Budget at the Whitehouse, the 1999 budget had the following spending distributions: 37% (\$792,525,999,248) for Social Security, unemployment, and labor; and, 19% (\$415,355,218,644) for Medicare and other health services.

⁸⁴ Older Americans Reauthorization Act of 2016, S. 192, Public Law No. 114-144, 114th Congress.

further complicates how it is that the good life aging is portrayed and achieved.

The pushback against welfare policies for aging persons that manifested itself quietly and more prominently during the 20th and now 21st centuries finds an ideological home in the liberal and libertarian view of autonomy promoted through American culture. Part of that history as observed by de Tocqueville, written about by Emerson, and mythologized in the stories of frontiersmen, comes from an American individualism that moves beyond the interpreted value placed on autonomy. Individualistic tendencies romanticized ideas of the self-made individual. That self-made individual, acting upon his or her right to autonomy, is valued for having thrived without the help of anyone else. This may be attributable to the American spirit before, during, and immediately after the Revolution regarding the establishment of American political and individual sovereignty but it is difficult to say precisely when this shift occurred. However, the history of individualism's influence on autonomy has clearly effected a change in how some Americans perceive the responsibility of the government in helping certain individuals or groups of individuals.

Born out of liberal autonomy's prominent place in American society, libertarianism is a platform for those who disagree with the government's assisting the aging (or other groups in need of financial or medical aid). A general libertarian critique of government intervention has been that the individual should not have his or her rights infringed upon by the government so long as fundamental freedoms are guaranteed; the government has no business involving itself in the private lives of individuals. Robert Nozick argues that the government is not responsible for ensuring the equitable distribution of resources or maintaining an equality that extends beyond basic freedoms. This is perhaps part of the reasoning behind some of the pushback against

policies involving government and social intervention directed toward taking care of a group of individuals who are either viewed as or are no longer being capable of taking care of themselves. Reasoning of this sort, combined with the mythologized value of the self-made individual in American culture, pushes the criticism of welfare programs to a more personal level – not being able to take care of yourself means not being American. In this way, the suite of welfare programs for the aging person symbolizes the very antithesis of the American notion of autonomy.

Ironically, this dispossession of one's American-ness regarding individualism and self-reliance was paramount during the Great Depression, the time that gave birth to the very safety net that would later be disparaged. Sweeping unemployment put a strain not only on the day-to-day responsibilities one had to one's family, but also called into question the very extent to which one was self-reliant. Achenbaum remarks "that one-fifth of all men who wanted to work still could not find jobs as late as 1938 painfully demonstrated that 'rugged individualism had fallen upon rugged times,'"⁸⁵ causing Americans to realize that the dreams of prosperity forged in the 19th century and believed to have been made possible during the industrial expansion of consumer society during the early 20th century were just that – dreams. As the economy recovered, however, the acceptance of Social Security as a necessary provision waned as individuals were able to return to previous earnings levels. During the 1950s Americans yearned for the restoration of the idealized male-centric rugged vision of self-reliance that evaporated during the Great Depression, and popular culture responded with literary, television, and film characters capable of taking care of themselves outside of the influence of a central

⁸⁵ Achenbaum, *Shades of Gray*, 30.

government.⁸⁶ Still, economic prosperity had not quite rebounded entirely, so the fictional images remained fictional until the era of the Great Society. As the economy experienced its longest sustained expansion during the 1950s and 60s, the pushback against the welfare programs, couched in libertarian terms, began. The economic boom, largely powered by the private sector, led to a further separation of socioeconomic classes, leaving certain groups, namely those who were already poor, but also the aging population, struggling to keep up and restore their own self-reliance. The question that emerged during this time was that of prolonged dependence on government welfare, specifically for the aging who had received special attention in the form of government-funded social programs to help aging persons achieve the good life. “Leaders in federal government did not expect, and the American public certainly did not want”⁸⁷ the welfare programs, Social Security Medicare Medicaid (and Welfare), to create either a group or a society that would be permanently dependent upon the financial support of the government. The policymakers maintained their optimism concerning the legislation passed during the Great Society era, but the idea that the government was continuing to involve itself in maintaining the wellbeing of the individual beyond securing fundamental freedoms during a time that did not require such direct help was not popularly believed to be germane to the government. The same pattern of support during time of economic crisis and protest during economic surge befalls American society today.

The problem, however, is more complex than the ‘libertarian self-made autonomous individual’ critique of the welfare policies. Aging persons are not homogenous despite the blanket categorization applied by the government vis-à-vis welfare policies. A diverse group

⁸⁶ Achenbaum, *Shades of Gray*, 67.

⁸⁷ Achenbaum, *Shades of Gray*, 100.

such as the aging complicates what is intended to be an equitable program that attempts to secure individuals' financial wellbeing. What Social Security does not account for is the varying level of contributions that individuals were capable of making over the course of their working lives. Embedded in what appears to be only a problem of socioeconomic class are the contributory problems of gender and race.

Noted during the time of the New Deal was the policymakers' belief that individuals, once financially stable, would continue to contribute to their own individual retirement funds, understanding that Social Security was intended to be temporary or at least a last resort. However, it became part of the foundation upon which many Americans built their retirement plans. If one's contribution to Social Security is contingent upon one's capacity to earn, the fact that racial minorities and women enter retirement at a significant disadvantage when compared to their white male contemporaries is exceptionally problematic. As mentioned above, the original Social Security Act enacted during the New Deal limited the types of jobs that were eligible for benefits, and this directly impacted racial minorities whose jobs did not qualify for the full benefit. Median income for full-time African-Americans in 2014 was roughly \$36,000 compared to the entire full-time working population's average of \$44,000.⁸⁸ African-American men fare better than African-American women regarding Social Security benefit collection - \$14,672 versus \$12,640. However, the Social Security Administration states that workers with lower wages receive a higher percentage of wages back compared to higher wage earners. Still, African-American life expectancy remains shorter than the general population – 65 years of age compared to 78.8 years, so the return on the benefit has a better chance of not being realized

⁸⁸ "Fact Sheet: Social Security Is Important to African Americans," Social Security Administration, <https://www.ssa.gov/news/press/factsheets/africanamer-alt.pdf>. Accessed January 25, 2017.

when compared to other racial groups. Hispanics with full-time jobs do slightly worse in terms of median income, earning \$31,760 per year, but they have above average life expectancies with Hispanic men at 85 and Hispanic women at 89.⁸⁹ Hispanic men received an average benefit of \$14,626 and women received an average benefit of \$11,172. Median wages for women working full-time were \$39,000 compared to \$49,000 for men, and female beneficiaries of Social Security received an average of \$12,857 whereas the benefits for men averaged \$16,590. Life expectancy for women overall was approximately 88 years of age and 86 for men. Beyond the evident disproportionate access to Social Security benefits experienced across sexes, classes, and races, what these statistics indicate is that the government's vision of wellbeing, understood as the financial and medical assistance necessary to live the good life in aging, is fundamentally flawed as it does not account for these glaring inequities. The type of health care one can afford throughout one's life is obviously based on one's income; however, if the type of health care to which one has access in later years is contingent upon contributions made during working years, is it fair to say that the policies actually intend to support the welfare of the aging population as a whole? No, aging persons from racial minority groups receive more limited care during their younger years and during the time in which they are most likely to need medical care. It is nonsensical to have a policy that aims to protect the health and financial wellbeing of aging persons when the policy does not seriously consider the diverse needs of that population. Issues of gender, class, and race are problematic in any analysis of economics, but there exists a different type of discriminatory practice that targets aging persons without concern for these otherwise important demographic descriptors.

⁸⁹ "Fact Sheet: Social Security Is Important to Hispanics," Social Security Administration, <https://www.ssa.gov/news/press/factsheets/ss-customer/hispanics-ret.pdf>. Accessed January 25, 2017.

The Social Construction Of Aging And Ageism

Unproductive. Financially insecure. Ugly. Dependent. Unhealthy. These descriptors, implied or explicitly stated, have been used throughout the above sections to demonstrate cultural and political perceptions of aging persons. While the terms used may accurately describe some individuals, they do nothing more than reveal the fact that aging itself has been socially constructed, and constructed negatively. Whether the aging person is viewed as un-American because of a lack of independence, viewed as sick given his or her failure to meet certain health standards,⁹⁰ or simply recognized as a 65-year-old who qualifies for government support, American culture has largely informed what it means to be a Third Ager and what that experience is or should be like; the aging person him or herself turns to cultural norms on direction for how to age well. Of the many ways in which the social construction of aging can be witnessed, the discriminatory practice of ageism is especially concerning.

Akin to the formula of other prejudices or stereotypes, ageism refers to “the negative attitudes or behaviors toward an individual solely based on that person’s age.”⁹¹ The term may not seem immediately relevant to the subject group of this dissertation, but members of the Third Age who may be financially insecure, experiencing new health care needs, transitioning out of the workplace and into new social and familial roles, and turning to the marketplace for guidance certainly are subjected to ageism. Operating discreetly by means of subliminal messages in pharmaceutical advertisements and workplace restructuring, or overtly in the claims that aging is a pathogenic condition, ageism’s effects reach Third Agers and anyone who is self-conscious of

⁹⁰ See Chapter One, pp. 38-45.

⁹¹ Jeff Greenberg, Jeff Schimel, and Andy Martens. “Ageism: Denying the Face of the Future” in *Ageism: Stereotyping and prejudice against older persons*, ed. Todd D Nelson (Cambridge, MA: MIT Press. 2002), 27.

age. Regardless of how it is communicated, this “alteration in feeling, belief, or behavior in response to an individual’s or group’s perceived chronological age”⁹² has far reaching effects on those outside and within the Third Age.

Margaret Morganroth Gullette argues that the theories of culture and (consumer) culture’s influence on aging illustrate what she identifies as decline. “Decline,” according to Gullette, refers to “the entire system that worsens the experience of aging past youth,”⁹³ which can be mitigated or exacerbated depending on one’s social context.⁹⁴ Aging itself, the physical and mental changes that one might naturally experience, is not what Gullette means by the term decline. She does not suggest that this process of aging is the problem, but rather that the problem rests in the ideology of aging-as-decline. This form of thinking permeates social, political, economic, sexual, and aesthetic beliefs of both the non-aging and aging alike. Thus, Gullette’s call is to “defy ageism, not aging”⁹⁵ for ageism⁹⁶ reveals the manner(s) in which aging is socially constructed. The complicated and sweeping effects of aging-as-decline are experienced in a number of areas of need, i.e. health care and the aforementioned high value placed on youth in the social imageries and the value of productivity exemplified by ageism in the workplace.

⁹² Becca R Levy and Mahzarin R Banaji. “Implicit Ageism” in *Ageism: Stereotyping and prejudice against older persons*, ed. Todd D Nelson (Cambridge, MA: MIT Press. 2002), 50.

⁹³ Gullette, *Agewise*, 5.

⁹⁴ Gullette, *Agewise*, 5.

⁹⁵ Gullette, *Agewise*, 118.

⁹⁶ Gullette extends the scope of the aging population to address what she calls that “middle-ageism” that affects those around and even under age 40. Interesting to note is that her use of such a term does not undermine the value of addressing the impact of traditional ageism in the dissertation; instead it supports how deeply rooted ageist tendencies are, and how those tendencies are fostered by culture before one is anywhere near age 60.

Economic and cultural factors come together in changing the landscape of the workplace and work force regarding the aging. Maintaining full-time work has become increasingly difficult for aging members of the workforce and has already begun trickling down to younger age groups.⁹⁷ Age discrimination in both the hiring and terminating processes, “job obsolescence, changing job-performance capabilities, and adverse institutional structures (such as mandatory retirement),”⁹⁸ are but a few of the problems aging persons face when it comes to maintaining or finding full-time work.

Though there are laws that prohibit discrimination based on age in both the hiring and firing processes of jobs, “negative stereotypes about older workers, as well as elderly people in general, may act as precursors to ageist discourse or discriminatory practices.”⁹⁹ The Age Discrimination or Age Discrimination in Employment Act (ADEA) of 1967 was designed to protect workers over age 40 from being passed over for employment based on age and as a means to increase job opportunities for older Americans so long as they were capable of whatever a new job might require. Despite the 20,588 suits filed in 2014, the Equal Employment Opportunity Commission (EEOC) ruled that 552 or 2.7% had reasonable cause, illustrating that age discrimination in the workplace remains difficult to prove.¹⁰⁰ The number of cases proportionate to cases determined to be reasonable may seem alarming, but what proves more interesting are the cultural biases that perpetuate the continued increase in such cases, those

⁹⁷ Gullette, Margaret Morganroth. *Aged by Culture*. (Chicago: University of Chicago Press, 2004), 80.

⁹⁸ Schulz, James H. 1992. *The Economics of Aging*. 5th ed. (New York: Auburn House. 1992), 70-1.

⁹⁹ Robert McCann and Howard Giles. 2002. “Ageism in the Workplace” in *Ageism*, Todd D Nelson, ed. Cambridge, MA: The Massachusetts Institute of Technology Press. 176.

¹⁰⁰ Equal Employment Opportunity Commission. *Age Discrimination in Employment Act Statistics*. <http://www.eeoc.gov/eeoc/statistics/enforcement/adea.cfm>. Accessed February, 7, 2016.

ageist tendencies that come with Gullette's era of decline.

Discourse in the workplace, casual or formal, can reveal much about the pervasive nature of implicit ageism. Talk of job performance or productivity oftentimes is employed to mask age discrimination in the hiring and firing processes – Robert McCann and Howard Giles identify 'young blood' remarks as often being used in lawsuits sent to the EEOC.¹⁰¹ Comments such as "we need some young blood around here," "let's make room for some M.B.A.s," or "let's bring in the young guns" may take on various forms in typical conversation, but they always reveal the belief that aging persons are replaceable and/or in need of replacing because they are *older*. There is a cultural perception that older workers demonstrate a natural decline in productivity alleged to begin once a worker turns 40; a decrease in productivity correlates to a decrease in the very value of the aging worker as person.¹⁰² However, research that explores the relationship between increasing age and decreasing productivity reveals no concrete causal relationship.¹⁰³ This lack of connection parallels the same argument made by those who believe that aging is a disease – research does not show that aging *always* brings about the same series of health issues,

¹⁰¹ Robert McCann and Howard Giles. "Ageism in the Workplace" in *Ageism: Stereotyping and prejudice against older persons*, ed. Todd D Nelson (Cambridge, MA: MIT Press. 2002), 181. The authors cite *Scott v. The Goodyear Tire and Rubber Company* (1998) in which executives commented "this company is run by white haired old men waiting to retire – and this must change" and that "some people will lose their jobs, but in time, we will replace them with young college graduates at less money." A second case, *Hoffman v MCA, Inc.* (1998), showed an executive remarking "I think we're going to have to get fresh legs in Chicago," but this case was dismissed as the remarks were too vague.

¹⁰² McCann and Giles, "Ageism in the Workplace," 173. This may be linked to a belief that the older one gets the more seniority (read: power) one should have in the workplace, and that if that level is not achieved by that aging worker, something must be amiss.

¹⁰³ McCann and Giles, "Ageism in the Workplace," 172. "Despite these commonly held negative perceptions, a large number of empirical studies and research reviews indicate that a nonexistent or slightly positive statistical significance exists between job performance and the age of a worker. In this vein, research has shown that the output of older workers is equal to that of younger workers, that older workers are better in terms of accuracy and steadiness of work output and output level, and that they outperform their younger counterparts in the area of sales."

yet the myth is perpetuated by physicians and ethicists. There may be individuals whose productivity dissipates, just as one's health may decline, but when a number of studies are evaluated there may be more truth in the claim that "older workers may actually be more productive than their younger counterparts, or at least on par with them,"¹⁰⁴ than in the idea that aging workers are less productive. What seems to be at work in perpetuating the myth that aging persons are less productive is the myth revealed in chapter one regarding the functional health of the aging.

An unsubstantiated belief that all aging persons experience a synchronous and uniform decline in physical and mental health contributes to an inhospitable workplace. However, the myth of inevitable cognitive impairment is most damaging. While "there are losses in attention and working memory with increasing age," which can present a problem insofar as individuals are capable of maintaining work performance and being trained to perform new tasks, "only a minority of older adults develop extreme impairment in the form of dementia."¹⁰⁵ Needing to be replaced on the grounds of productivity is one thing, on the sole basis of age is another; however, there remains a perceived link between the two, a link that is pseudo-science at best. The myth that all aging persons experience cognitive decline and are thereby incapable of working at all, contributes to a work culture that impedes the willingness of employers to spend time improving the aging worker, let alone hire aging members of the workforce.

Continuing in the pseudo-scientific realm of ageist myths, aging persons are generally

¹⁰⁴ McCann and Giles, "Ageism in the Workplace," 172.

¹⁰⁵ Susan Krauss Whitbourne and Joel R Sneed. 2002. "Paradox of Wellbeing, Identity Processes, Stereotype," in *Ageism: Stereotyping and prejudice against older persons*, ed. Todd D Nelson (Cambridge, MA: MIT Press. 2002), 248.

thought to be resistant to and even unable to change. Whether there is an underlying cognitive pathology that may justify a resistance (i.e. prior traumatic life experience with a certain type of labor practice) to change or not, the perception is that an old dog cannot be taught new tricks. Such a belief may not only lead to an employer's firing an aging worker, but also might stymie the worker's chances of obtaining a job later in life. A number of studies point to "strongly held societal beliefs that older people are unwilling to change" and effectively "not worth training because they will not be around long, learn too slowly...and are computer illiterate."¹⁰⁶ Beliefs that aging persons are generally set in their own ways take on a unique tone when applied to the workplace because such beliefs can be transformed into discriminatory practices that can damage one's sense of worth or value, and more tangibly, financial security. Again, however, normative claims about the rigidity and inflexibility of aging persons have been proven untrue by a number of studies, and aging-person specific training initiatives among several Fortune 500 companies demonstrate that the aging person's ability to learn new skills is on par with younger trainees.¹⁰⁷ However, societal beliefs about the difficulty that comes with training and a perceived decline in productivity persist despite evidence to the contrary. These conscious or subconscious beliefs, when coupled with the realities of financial security and correlative end-of-work policies illustrate the convergence of the social construction of aging and ageism.

Financial security for the aging population has been a public concern in the US since the time of FDR, and it has been seen as integral in fulfilling the good life as one ages, yet achieving that security can be rather complicated. The complex difficulties of attaining financial security highlight the relationship between the social construction of aging and ageist claims. On the one

¹⁰⁶ McCann and Giles, "Ageism in the Workplace," 171.

¹⁰⁷ McCann and Giles, "Ageism in the Workplace," 171-2.

hand the aging worker is told by society that he or she will be able to stop working and enjoy more leisure time once he or she reaches the requisite age for Social Security benefits. On the other hand, the aging individual is confronted with the aforementioned difficulties in keeping the necessary full-time employment that enables an adequate level of contribution to Social Security. All the while, the retirement age of 65 itself, which exists as the point of demarcation for the receipt of benefits, has been arbitrarily chosen. Outside of the existence of the Social Security Act and its requisite age for benefit collection, there exist no conclusive studies or sound rationale that legitimize any claims regarding when an individual should no longer work. Retirement is a relatively new concept that responds in part to increased longevity and to the belief that one should have time to enjoy the benefits years spent working. The time when one should retire does not necessarily reflect the needs or wishes of the aging worker, but rather the wishes of the employer. As has been explained, the older worker is often viewed as no longer productive and incapable of learning anything new to improve productivity, thus there is a need to move the aging person out of a given job and replace him or her (with a younger and oftentimes less costly person). With 65 having become the marker for the time when one is no longer expected to work, companies and society alike expect that individuals will remove themselves from the workforce at that time. If 65 is too late from the employer's perspective, more appealing retirement packages may be offered so as to help facilitate the removal of the aging person.¹⁰⁸ Pensions have contributed to the belief that individuals should retire at 65 or even younger. For those who are financially secure enough to supplement Social Security

¹⁰⁸ In higher education, for example, moving full professors out of their roles and replacing them with several young(er) adjunct professors is minimally a cost savings to the college or university. Without trying to sound ageist and self-serving (it invariably will), younger part-time faculty may also bring a department unique perspectives and a proverbial breath of fresh air.

benefits with pensions, retiring ‘as early as possible’ may be encouraged. Some employers have gone so far as to make the process of retiring early easier and more cost effective by “absorbing all or most of the added costs of paying pensions out over a longer period of time,” and creating even more appealing early retirement incentive programs that offers workers “credits to increase their pension levels or a lump-sum payment (typically equal to one-half to two years’ salary) in addition to their regular pension.”¹⁰⁹ Retiring early enables individuals to enjoy more leisure time and more of the comforts that one has earned, which happen to coincide with societal norms regarding what the retired person is supposed to do and when the aging person is supposed to retire (i.e. spend time with family, care for grandchildren, serve the community, leisure activities). However, the security provided by retirement benefits does not necessarily guarantee the good life in aging; in fact, this sudden change for the life-long worker can leave the retired person “feeling isolated and confused,”¹¹⁰ wondering what to do.

To summarize, the social construction of aging and ageist beliefs and practices reinforce one another. The social construction of aging perpetuates ageist beliefs and practices in the workplace, and these further entrench socially constructed views of aging. No longer regarded as capable of productive employment at Job A, the aging person is let go, and because of the belief that older adults are less capable of adapting to change or are difficult to train, they cannot find new Job B. The aging worker needs Job A in order to retire comfortably, regarding health and financial security, per society’s standards, but can be manipulated into a forced retirement or let go because of a decrease in productivity. If displaced workers do find new work, they will

¹⁰⁹ Schulz, *The Economics of Aging*, 81-2.

¹¹⁰ McCann and Giles, “Ageism in the Workplace,” 175.

“typically recover only a percentage of their salaries; some [will] need two jobs” whereas their younger replacements can have a greater potential for earning more than the outgoing aging worker.¹¹¹ Needing to work longer, aging persons return to the job search and face the problem with which this example began. All of this has been considered for the aging population identified in this dissertation, but the problem is beginning to impact younger adults.¹¹² If the aging person around 62 finds difficulty with these issues, imagine the anxiety over financial security faced by the 50-year-old who is not close to retirement but is subjected to the same types of ageist tendencies as older adults. Consider those who lost work, homes, and retirement savings during the Great Recession—those aging persons suffered greatly and may not ever have a chance to age well. This creates an endless series of problems for the aging person who wishes to work so as to achieve the good life in aging.

Ageism underscores the value placed on youth in society. Whether in the workplace or in popular images mediated through consumer culture, the youthful person or healthy youthful body is identified with the good life. Individuals in the workplace capable of doing good work are those who are young while those who physically appear to be older or are older are stigmatized. Assuming that productivity is linked to age, and continuing to push the perceived age-based productivity line down toward increasingly younger ages, undermines the aging person’s ability to achieve the good life in terms of one’s autonomy as a producer and as a consumer vis-à-vis having the necessary finances to fulfill one’s own or a culturally determined vision of the good life. If the workplace itself becomes an impediment to an individual’s expression of autonomy and the free market cannot adequately fulfill the desires of the

¹¹¹ Gullette, *Aged by Culture*, 82.

¹¹² Gullette, *Agewise*, 8-15.

individual, then autonomy itself has been denied. Compounded with the images of the good life communicated through consumer culture and the beliefs emerging from the 'aging as disease' school of thought precipitated a principle of autonomy in biomedical ethics whose creation absorbed the entirety of the history of American autonomy in a consumer culture that commodified wellbeing.

Conclusion

Aging persons in America are told, directly or indirectly, that the good life can be or is achieved by remaining independent and autonomous, continuing to participate in the economy as a consumer of goods and services, and appearing to be more youthful. The interwoven history of independence and individualism, coupled with consumer culture, present aging persons with a complicated narrative to which they are asked to respond. Unfortunately for the aging, the force of such cultural beliefs can derail them from ever identifying and pursuing the good life as they themselves may see it. While this assessment may be applicable to other groups within society, the aging are unique in that they will have had a long period of social and economic participation, and they will have contributed to the very narratives to which they are called to respond. As Third Agers, they suddenly - or not so suddenly - find difficulty in being able to clearly see and move toward what will afford them the type of good life they have been promised and/or that they have envisioned. The individualistic identity that is so highly valued in and through American culture transforms autonomy into a principle of self-determination that reduces freedom to pursue the good life to existential freedom alone. Transitioning from primarily being a producer who consumes to strictly a consumer can be difficult for those who have spent a majority of their adult lives identifying themselves as someone who does X or is an

X-er. Instead of being identified by what one does, the aging persons is are identified by their possessions, whether that be in the form of material goods or a youthful appearance. If one is no longer capable of contributing to the good of society in terms of productivity then one has forfeited, at least partially, one's right to be locus of social concern. Gullette suggests that this is not only part of the producer-consumer transition, but also a natural progression of public opinion. The welfare policies were developed to assist helpless individuals who had no opportunity, but today aging persons have been afforded a surplus of opportunity to prepare and generally are better prepared for personal and social life after work.¹¹³ Failure to prepare adequately over the course of one's life is no reason for continued socio-political support; however, being unable to prepare is. Gullette's observation of the populace's disposition toward helping care for the aging points to the way in which the social construction of aging and ageism has been fueled by the values of consumer culture.

What remains puzzling is the idea that on the one hand culture promotes productivity as the path to enjoying the good life while on the other social and political practices push individuals from the realm of economic productivity to that of consumption without offering much help beyond the minimal financial and health benefits. In such a time of vulnerability and ambiguity, there is a natural turn to sources that guide aging persons through this existential change. However, what is offered by culture is not necessarily as accommodating or sympathetic as one might have hoped and instead further complicates an already uncertain period of one's life. Perhaps what is needed is a look to other perspectives that can better work to counteract the rather detrimental views of aging coming from American culture.

¹¹³ Gullette, *Agewise*, 11.

CHAPTER THREE

AGING WELL IN THEOLOGICAL DISCOURSE

Introduction

The previous chapters have sought to offer competing models of aging well while examining the socio-cultural context in which such models are received. Medical perspectives emphasized that aging well was inextricably linked to good physical and mental health. Medical ethicists responded to that very one-dimensional assessment of the good life by attempting to resolve a more complicated question regarding whether or not aging itself was pathogenic or a natural part of life – a question that continues to be debated. A coincidental development in gerontology attempted to do the work that biomedical ethicists should have been doing at the time, namely, publicly discussing how one might age well. That discussion within gerontology was very much rooted in developmental psychology, and focused on psychosocial struggles and the sense of achievement or completeness afforded by such psychological progress. Still, what was offered from medicine, biomedical ethics, and gerontology, lacked any sort of systematization, any consensus, and worse, any normative teeth. This shortcoming has only been further complicated by the context in which it was evolving – an individual-centric and consumer-driven American culture that struggled and continues to struggle with what is to be made of aging persons. What is necessary, then, is an alternative perspective capable of addressing the holistic needs of the aging person while also proposing an approach to an ethics of aging that is responsive to the diversity of the modern American aging demographic. An

alternative approach will both describe the intrinsic value of the aging process and demonstrate how an aging individual might live the good life in the Third Age and beyond. The Christian tradition is one such discipline capable of informing an ethics of aging for modern Americans.

Given Christianity's place in the history and development of biomedical ethical discourse, it is necessary to analyze its insights regarding the question of aging well as the pursuit for an ethic of aging proceeds. When considering the range of contributions made by theology and theological ethics to the question of aging well, it is important to examine first the insights of Scripture and then those of the tradition as a whole.¹ Biblical scholarship, albeit limited vis-à-vis aging persons, offers several important insights that can begin the work of countering the negative socio-cultural narratives posed in chapters one and two. Likewise, the theological tradition serves as a source of insight. Again, what is necessary is that the surveyed commentaries on aging be read as pieces of a broader, though disjointed, Christian theo-ethical perspective on aging persons and the good life. First, then it is important to go to the beginning and look at several of the themes emerging from Scripture.

Gordon J. Harris' benchmark work *Biblical Perspectives on Aging* recalls and examines the "stories, poetry, and character studies"² of aging and elderly persons in Scripture, particularly the Old Testament. The Bible "certainly had a concept of old age and aging" and the stories

¹ Ahearn, David Oki and Peter R. Gathje. *Doing right and being good: Catholic and Protestant readings in Christian ethics*. (Collegeville: Liturgical Press, 2005), 33. These are but two sources of Christian ethics. The others, reason and experience, complete the group of four that constitute the Wesleyan Quadrilateral. David Oki Ahearn and Peter R. Gathje explain the beginnings of the quadrilateral: "The *United Methodist Book of Discipline* describes the Wesleyan quadrilateral this way: 'Wesley believed that the living core of the Christian faith was revealed in Scripture, illumined by tradition, vivified in personal experience, and confirmed by reason.' In the intervening years, this way of understanding the relationship of sources has entered into the common vocabulary of Christian theological ethics. All Christian denominations and theorist draw from all four of these sources, though they differ in how each is understood and the relative weight given to a particular source."

² Harris, J. Gordon. *Biblical Perspectives on Aging: God and the elderly, second edition*. (Hoboken: Taylor and Francis, 2013), 13.

presented “have given us a variety of perspectives,”³ integral for an ethics of aging. Harris admits that there is no systematic theology of aging but is convinced that there are “clues about general attitudes and practices.”⁴ A sampling of Harris’ findings will be covered below, but suffice it to say that among the attitudes toward aging and behavioral pre-and proscriptions, one theme clearly emerges: aging persons hold a special place within the community.

A number of biblical characters are said to have lived past age 100 with some reaching 900 years⁵ – the accuracy of which must always be viewed through the prism of symbolic importance (i.e. long life demonstrating someone who was in God’s favor). With few exceptions, the chronological age of such characters is not explicitly stated with biblical authors tending to use expressions of age rather than numbers to describe older individuals. Idioms such as ““full of days or advanced in years,”” writes Gordon Harris, were used in conjunction with vaguely defined age ranges of “childhood, youth, young married, and elderly”⁶ to connote the social stature of the individual. The term elder often came with an individual’s having achieved a leadership position, but such a status could be earned as early as age 30 or 40.⁷ In some Ancient Near Eastern communities, 50-year-olds were considered to be “of ripe old age.”⁸ Regardless of the precise numbers attached to various stages of life in the Bible, Harris concludes that “old age

³ Knierim, Rolf. “Age and Aging in the Old Testament” in *Ministry with the Aging*, ed. William M Clements (San Francisco: Harper and Row Publishers, 1981), 21.

⁴ Harris, *Biblical Perspectives on Aging*, 6.

⁵ Note: All Scriptural references are taken from the NRSV translation. In Genesis 5, ‘The Generations: Adam to Noah’, notable ages include: Adam 933, Seth 912, Methusaleh 969, and Lamech 777. All of these men fathered children well after their 100th birthday.

⁶ Harris, *Biblical Perspectives on Aging*, 54-55.

⁷ Harris, *Biblical Perspectives on Aging*, 58.

⁸ Harris, *Biblical Perspectives on Aging*, 55.

in the Bible signifies the transition into a weakened social and physical condition,”⁹ and therefore establishes the basis for the notion that surviving into old age was only made possible through God’s special concern for the aging; aging is regarded as decline, yet accompanied by grace.

According to the Old Testament, the manner in which special attention was to be paid to aging members of the community is born of two interrelated notions: God’s beneficent nature regarding Israel’s chosen status and God’s calls for justice within a society. Harris argues that the special care provided to older members of society is a direct result of the Exodus story in which God reveals God’s “intense passion for the welfare of strangers and the dispossessed.” Aging persons who might lose their ability to see or hear are included in Leviticus’ condemnation of mistreating disabled individuals.¹⁰ Likewise, other impoverished persons, such as older people, in need of food and shelter are identified as the helpless ones for whom God cares and for whom the rest of society is called to embrace and care.¹¹ Despite their physical limitations and exposure to social marginalization, older persons were believed to be integral in daily religio-social functions. Older persons, having an esteemed place in society vis-à-vis God’s having made possible their living into later years, were understood to be the conduits through which God was able to communicate God’s word. Not only was this done pragmatically through the transmission of Scripture and tenets of the Jewish faith, but also through their overseeing and practicing rites

⁹ Harris, *Biblical Perspectives on Aging*, 57-58.

¹⁰ Harris, *Biblical Perspectives on Aging*, 103.

¹¹ Harris, *Biblical Perspectives on Aging*, 104.

and serving as arbiters of legal disputes within the community.¹² Still, God's graces did not primarily work to overturn or even thwart the biological signs of aging, with several notable exceptions.¹³ The point remains, however, that God did not intervene in the lives of older persons for the purposes of restoring their youth or needlessly extending their lives—there was a divinely appointed meaning to life uninfluenced by cultural norms. Regardless of the physical effects of the aging individual's journey into the later years, one was given profound religio-social responsibility and essential to the continued flourishing of the community.

However, simply because an aging person experienced the physical and mental effects of the aging process, Knierim notes that there was not an association of aging itself with death like there is today, but certainly aging was known to come with some form of decline. Because of aging's special status, the process itself was not believed to be a disease in and of itself, despite biblical times presenting myriad threats to life, medical or otherwise. "Deadly diseases, accidents, killing, hunger, and war"¹⁴ were part of the lived experience of every generation, further distancing any correlation between one's age and proximity to death. Death was viewed as a single event marking the end of life rather than part of a developmental stage. Therefore, it was not treated with such public aversion or need for reversal or delay. Instead, those who lived into later years were lauded as having lived a full and well-rounded life, despite whatever decline

¹² Barak, Y and Achiron, A. "Age Related Disorders in the Bible" *Aging and Mental Health* (1998); 2(4) :275-278, 276.

¹³ In Genesis 21, Sarah, who previously states that God has prevented her from bearing children (16:2), gives birth to Isaac at the advanced age of 90. Sarah's age is revealed in Genesis 17:17. In this case, God is directly responsible for overturning the physiological functioning of the aging body.

¹⁴ Knierim, "Age and Aging in the Old Testament," 22.

may have been experienced because they were able to live for a long time.¹⁵ Because of more a widespread acceptance of aging as natural, aging was viewed as a blessing despite decline, and was sometimes even viewed as an opportunity for honor. That honor could be the type that one demonstrated by responding to God's grace and loving others and transmitting the faith. Honor could also be bestowed upon the aging by others, thus an obligation imposed on others within the community by God to care for the aging.

The Book of Proverbs¹⁶ articulates a special condemnation for the children of older parents who might mistreat or steal from their vulnerable parents. Harris explains that mistreating one's parents is the equivalent of murder insofar as the act of stealing from an ailing parent could very well hasten his or her death.¹⁷ A famous story of parental care is that of Jacob's deception of his father, Isaac in Genesis 27. The story is important for two reasons: it points to the notion that taking advantage of older persons is a long-practiced problem, and that the one who takes care of the aging parent gains God's favor (regardless, unfortunately, of the deceit involved). Important to note is how central the parent-child relationship was in maintaining justice in biblical society. "Israel's legal collections strengthen social structures and order by stressing obedience to and respect for the older generations,"¹⁸ which are reflective of secular legal and social codes of contemporary societies in Mesopotamia, Egypt, and Canaan.¹⁹ It was widely known that dysfunction between the older, believed to be better equipped at

¹⁵ Knierim, "Age and Aging in the Old Testament," 23.

¹⁶ Proverbs 28:24, "A person who robs father and mother and says 'There is nothing wrong with it,' becomes the accomplice of a murderer."

¹⁷ Harris, *Biblical Perspectives on Aging*, 104.

¹⁸ Harris, *Biblical Perspectives on Aging*, 74.

¹⁹ Harris, *Biblical Perspectives on Aging*, 59.

organizing and maintaining order within a society, and younger generations would result in tumult capable of destabilizing an entire society. Thus, care for the aging was both religiously and socially necessary, the relationship between which Harris admits is difficult to distinguish.²⁰

What can be said about the insights offered by both Harris and Knierim is that there are two important themes with a causal relationship: God claims aging persons as special, and aging persons are to be cared for by members of the community. In a number of stories, it is the elderly members of a society who are described as being in God's favor, inferred as a direct result of their age. Being an aging individual in a biblical community signified one's achievement in overcoming the inherent difficulties in living into one's 50s and 60s in the ancient Near East – a feat believed to have only been attributable to something else, something otherworldly, something divine. God's *enabling* the aging to continue on in years indicated to the people that they had also succeeded in achieving God's vision of a just society. God's role in the aging process itself presents a positive vision of aging that stands at odds with today's aging narratives. However, the biblical vision of aging well only represents one contribution from the Christian tradition.

Theological models addressing the aging have relied upon a somewhat Thomistic framework highlighting the spiritual or supernatural ends of the person and/or the practical or natural ends of human life. In focusing on the faith life, the practice of theological virtues is seen as integral to aging well, and satisfies the practical needs of the aging person. Approaches that emphasize the practical needs of the individual make use of other virtues whose practice may then bring about the good life for the aging person. The details of these approaches will be explored below, but, generally, the literature emphasizes faith and hope as first steps toward

²⁰ Harris, *Biblical Perspectives on Aging*, 71.

aging well, and emphasizes additional essential virtues needed to age well. A number of texts dealing explicitly with the theological virtues are spiritual or pastoral/ministerial in nature. These will not be considered below for several reasons. Though they are important, the texts do not necessarily contribute to an ethics of aging – they lack a normative schema that outlines what is central to aging well in the Christian tradition. Little to no attention is paid to the type of responsibility the aging person has as an agent regarding his or her own contribution to aging well vis-à-vis peers and other members of society. The pastoral literature also falls into biomedical ethics' trap of connecting aging with end-of-life care, and it is mostly tailored toward dealing with death – an *ars moriendi*. Interesting to note is that the theological literature of this 'aging-as-dying-well' tradition is that it is a marked shift from the biblical notion that death was a single event or moment rather than a process. Given that change in perspective, the spiritual literature, albeit unknowingly, adopts a perspective on aging that undermines the possibility of aging well.

Theological Perspectives Of The Good Life In The Third Age

A theological ethics of aging is a necessary response to the social question of the Third Age. It remains true that a Christian ethics of aging can be gleaned from the tradition by making use of concepts of human dignity, love, and justice (as was the case with some of Harris' scriptural findings); however, the specific application of those concepts to aging persons is not necessarily the focus of the teachings in which they appear. In the following section, I will address the faith-based responses to aging that explore the relationship between aging and suffering, the virtues ethics responses that attempt to identify the various practices understood to be integral to aging well, and I will end with two newer approaches that move into an ethics of care for aging persons.

Aging And Suffering

Richard's "Toward A Theology of Aging" begins with an admission that theology has "never concerned itself directly with the phenomenon of aging."²¹ He gives credit to the work of David Tracy²² and Henri Nouwen²³ who attempted to apply elements of Christian theology to the aging population, but notes their inadequacy in addressing the question of "what can be done to transform the oppression of the elderly" and "what pragmatic consequences should follow from a theology of aging?"²⁴ Richard believes that these authors fail in their lack of awareness of and response to the cultural context of aging persons has been insufficient given the power of culture's negative perception of aging persons. In response to the cultural context of aging being inextricably linked to the loss of self and self-rejection, Richard argues that "a frame of reference

²¹ Lucien Richard. 1982. "Toward a theology of aging." *Science Et Esprit* 34, no. 3: 269.

²² See: Tracy, David W. 1975. "Eschatological perspectives on aging." *Pastoral Psychology* 24 no. 299, 119-134. Tracy explains that understanding this way, "The Christian doctrine or symbols of eschatology bear intrinsic disclosive power for illuminating certain important dimensions of our common human experience of the process of aging: our sense of temporality and history." By placing our lives in the context of the already and not yet dimensions of eschatology, a more cohesive understanding of human life can be uncovered. Lack of attention to the overarching trajectory of our lives is limiting. Tracy believes that thinking about life as "atomic moments" which are parts of a cycle of experience of "another now" offers no help in providing meaning in the aging process nor can the past or future aid in providing a context within which the present occurs. Only by being able to connect the proverbial dots is it possible for one to understand him or herself as an individual and as a person embedded within a larger structure. Awareness of the "three modalities of time – past, present, and future" provides a "horizon of meaningfulness, an orientation to the value" of life and of aging that minimally offers a pause for reflection and ultimately enables an individual's receptive posture to the temporal and eternal life. Thus, an appreciation for the eschatological dimension not only helps individuals deal with the issue of mortality vis-à-vis the triumph of Jesus, but it also offers a way in which humans can find meaning in their lives beyond a stitched together series of moments, which may impede personal fulfillment for the aging person who cannot see beyond her immediate circumstance.

²³ Henri Nouwen's *Aging* offers a theo-spiritual reflection on the process of aging that is applicable to aging persons themselves as well as their caretakers and those with whom the aging will be in contact through the later years. Nouwen emphasizes that aging is not a time for despair but a time for hope and joy in that God's promise of salvation is close at hand. Aging is not to be feared; instead aging should be embraced as a natural part of human life that offers new opportunities for one to engage in spiritual and religious life.

²⁴ Richard, "Toward a theology of aging," 272.

where loss and negation can be affirmed without falling into a permanently enervating despair”²⁵ is the necessary counter-narrative capable of re-contextualizing the Third Age as a period of life and hope. The current narrative, replete with negative cultural images, ageist social norms and practices, “provides no set of values that can represent aging as a process worth the effort.”²⁶ If there is to be a genuinely fulfilling model for successful aging there must be a reorientation of American culture, liberation from “a functional ethic which suggests that self-worth is contingent on performance in economic and social positions.”²⁷ The process in which aging persons and American culture itself in general can be liberated begins with the cornerstone of the Christian faith, the Paschal Mystery.

Instead of attacking the cultural and social norms that alienate aging persons in an attempt to offer a corrective for the system that birthed such norms, Richard uses the themes of alienation and self-rejection as an almost positive starting point. Inspired by *Gaudium et spes*, Richard argues that even within the theological discourse the profound meaning of the Paschal Mystery has been diminished – God’s presence among humanity was reduced to a completed historical act that only set the stage for the fulfillment of the eschatological promise.²⁸ Absent from Richard’s analysis, but helpful in further understanding Richard’s vision is Johann Baptist

²⁵ Richard, “Toward a theology of aging,” 275.

²⁶ Richard, “Toward a theology of aging,” 275.

²⁷ Richard, “Toward a theology of aging,” 286.

²⁸ Richard, “Toward a theology of aging,” 276. Richard argues that theologians have focused on the resurrection as being the definitive moment in which evil was conquered. “The cross becomes the symbol of an evil that has no longer any power over us; that no longer needs to be taken seriously. The impact of the ‘already here’ has blocked out the cutting edge of the ‘not yet.’” He further remarks that “Christianity in North America replaces the ‘already/not yet’ with a straightforward ‘already,’ suggesting that the triumph of the Cross is interpreted as letting American Christians off the hook regarding their faith lives and the manner in which they conduct themselves.

Metz's two categories of religion: bourgeois and messianic.²⁹ Bourgeois faith is characterized by taking life and the future for granted, and "affirms autonomy, competitive struggle, property, stability, and success."³⁰ It is this type of lazy faith of which Richard is critical, particularly how that type of faith life is perceived to represent the good life in aging. Metz's messianic faith, however, is what Richard hopes the aging Christian can live out in the Third Age. The messianic faith is one that inspires unconditional love for all, compassion, and virtuous living. Thus, Richard moves to remind Christians of the Mystery's significance, specifically the way in which God's kenosis³¹ changes the very meaning of the human experience vis-à-vis suffering. In doing so Richard turns what culture has determined to be a negative experience, aging, into a deeply meaningful religious experience.

Transforming a culture "based on domination and mastery" into one that "underline[s] man/woman's poverty; man/woman, the receiver,"³² requires that the alienation that culture forces upon the aging be reframed around the positive experience of being finite and contingent vis-à-vis the Paschal Mystery. For Richard, this is made possible through a 'theology from below' that views Jesus' suffering as an act of love. Not all that dissimilar from other liberation theologies, the theology of aging advocated by Richard starts with the plight of the aging person, with both its physical and mental effects as well as the social marginalization, recalling that

²⁹ Metz, Johann Baptist. 1981. "Toward the Second Reformation: The Future of Christianity in a Postbourgeois World." *Cross Currents* 31, no. 1:85-98.

³⁰ Hanchin, Timothy. 2006. "Messianic or Bourgeois?" *America*. Vol 194. New York: America Press.

³¹ Based on Philippians 2:7, which explains God's emptying of God's self into a human servant, kenosis (and kenotic theory) stresses the importance of the Incarnation as a profound act of God's love. By taking on the human form God attaches God's self to the rest of creation God very really surrenders part of God's being for the benefit of humanity.

³² Richard, "Toward a theology of aging," 277-8.

Jesus' "total participation in our finite powerlessness" has made "suffering and death the central interpretive principle of God's nature."³³ It is in the actual suffering, in this case the aging person's physical, cognitive, or psychological suffering, that one begins to come to understand, albeit limitedly, the type of self-sacrificial love God has offered to humanity and asks to be reciprocated. The acceptance of such suffering as being part of life provides a "deeper love for reality"³⁴ grounded in the hope that life is wholly meaningful. However, it may remain challenging for the aging person to accept that the type of suffering endured is an act of love or opportunity for one to experience God's love. Richard moves to address this apparent disconnect by expanding on the theology of kenosis or kenotic Christology.

Turning to the events of the Cross and its aftermath Richard suggests that aging persons can begin to identify with the type of self-emptying that provides the basis for coming to realize the type of good life that can be experienced in aging. The Cross is symbolic of God's entering into the suffering of humanity, and particularly the suffering of the oppressed, those whom Jesus championed. In the self-surrender demonstrated on the Cross Jesus accepts God's plan and affirms his own love for humanity and love for God – the mark of complete dependence upon God. Relevant to aging individuals, the "conversion to the 'crucified Christ' liberates" the Third Ager who has been conditioned to understand one's existence in a particular way by directly confronting "cultural and social illusions."³⁵ No longer is the aging person limited in how she or he can understand the self, no longer is the aging person determined from without; instead, the

³³ Richard, "Toward a theology of aging," 280.

³⁴ Richard, "Toward a theology of aging," 281.

³⁵ Richard, "Toward a theology of aging," 281.

liberating experience of the Cross enables the aging person to love as Jesus loved, to truly live.

This use of kenotic Christology takes the perceived negative interpretation of dependence in aging and adjusts the hermeneutic such that the love practiced by both God and Jesus on the Cross reaffirms God's "love of the unworthy, the worthless, the lost...characterized by its universality."³⁶ In effect, the events of the Cross and the love it displayed, and continues to display, exemplify the truth of living interdependently.

Standing in contradistinction to the American cultural ethos, Richard argues that individual independence is not the essence of the human experience, and is therefore not an appropriate value to hold absolutely. Humans are and always will be dependent or contingent, never fully capable of mastering the world and always intertwined with the lives of the other, a point to be taken up further below regarding care in an ethics of aging and in the following chapters concerning dependency and communality. The interdependent life modeled by Jesus "is one of radical mutuality and reciprocity, of giving and receiving, of giving so completely from and for the other that nothing is left of self-centeredness."³⁷ Richard directly denounces the type of absolute autonomy espoused in American culture, saying that it is but an illusion precisely because our very being is dependent on the other.³⁸ The Third Age represents a period in which the experience of interdependence is highlighted in new and unique ways capable of reminding the aging person that he or she is not entirely autonomous and/or self-sufficient despite what one might believe. Surely the shift from independent adult to an increasingly dependent aging person

³⁶ Richard, "Toward a theology of aging," 283-284.

³⁷ Richard, "Toward a theology of aging," 284.

³⁸ Richard, "Toward a theology of aging," 284.

is dreaded; however, the fear is constructed by a culture that is incapable of discovering “meaningfulness for situations of limits, finitude, suffering, and losses.”³⁹ Richard believes that the surrendering of the self to the Cross will enable the construction of an “un-American consciousness of finitude and limitation” that will promote a model of successful aging capable of accepting “limitations, conditioned autonomy and freedom.”⁴⁰ This model for aging meshes well with Callahan’s approach to health care rationing for aging persons based on a religiously grounded form of disengagement and re-engagement – the aging person will become more limited as nature progresses, but there remain other meaningful opportunities in the Third Age for active involvement that counteract discriminatory and demeaning cultural narratives. Once an aging person has given him or herself over to God’s salvific power and rejected other alleged forms of salvation, i.e. life-extending medical technologies or the notion of vitalism⁴¹, the aging person can move closer to his or her destiny.⁴² Richard concludes that the theology of aging, rooted in kenosis and hope, offers the “ultimate form of engagement” for the aging person who will now be able to face life “realistically without deception and the ‘new life’ without undue fear.”⁴³

Henri Nouwen had tried previously to address this issue of the good life, arriving at a

³⁹ Lucien Richard. 1991. “Aging: Setting Limits with a Christian Vision: A Theology of the Paschal Mystery.” *Journal of Religious Gerontology* Vol. 8(1): 31.

⁴⁰ Richard, “Toward a theology of aging,” 286.

⁴¹ Vitalism is a position maintaining that life itself is the greatest possible value. Vitalism advocates for life to be sustained at all costs. Catholic theological ethics tends to disagree with the claims of vitalism in a manner akin to that of Richard on the grounds that the Resurrection and the eschatological promise do not allow for Christians to place earthly life over eternal life.

⁴² Richard. “Aging: Setting Limits with a Christian Vision,” 36.

⁴³ Richard, “Toward a theology of aging,” 287.

conclusion similar to Richard's: "fearless surrender in which the distinction between life and death slowly loses its pain"⁴⁴ will provide a sense of meaning to the aging person in the midst of competing socio-cultural values and norms about aging. Nouwen believes that "a gentle letting-go" is the first step in what is needed to allow the aging person to "break through the illusions of immortality and smile at all the urgencies and emergencies" of one's life, finally arriving at "the true reasons for living."⁴⁵ Yet the true reasons for living, beyond the hope provided by the Christian faith, is a task or duty that takes on new meaning during the Third Age, namely to love and care for others. That love and care starts with the self, and then flows outwards.

Nouwen suggests that in order to better care for the aging self, the aging person must first reaffirm one's self-worth. Losing a sense of the self can be attributed to the aforementioned cultural factors influencing how aging is perceived, but Nouwen suggests that the problem lies more in an individual's belief that he or she does not change and will always be the same person. "The old man awakening at our own center" writes Nouwen, is perceived as the "intruder threatening to rob us of what we consider our own."⁴⁶ In clinging to the idea that we never will change, the process of aging is jarring for someone who does not gradually adjust to the natural changes of physical, mental, and psycho-social development. In order to care for oneself, one must come to embrace the idea of becoming old so that one may begin to first care for oneself and heal. Nouwen explains that embracing the aging process as poverty-inducing is analogous to the total detachment found in Richard's kenotic Christology. The poverty experienced by the aging person allows him or her to let go of that which provides the illusion of ownership and

⁴⁴ Nouwen, Henri J.M., and Walter J. Gaffney. *Aging*. (Garden City, NY: Doubleday, 1976), 79.

⁴⁵ Nouwen, *Aging*, 77.

⁴⁶ Nouwen, *Aging*, 101.

control over one's life and one's surroundings – those external forces that are otherwise responsible for the marginalization of the aging persons. In that poverty, the aging person can begin to reclaim whatever self-worth one has lost in the process of aging; a self-worth that is capable of transcending the natural and socially constructed limitations placed on the aging person.

However, Nouwen believes that the care for the self and reclamation and reinvention of self-worth in aging is impossible without the assistance of the other, the younger other, which can perhaps be interpreted as his harkening back to the Scriptural and early Church history of Christianity, but the relationship with younger generations is not one based in physical care or respect for elders. Instead, Nouwen's belief raises the psycho-spiritual benefits the aging person can reap from a productive relationship with younger persons. While rediscovering the self, and finding meaning in aging, Nouwen argues that the encounter with the younger other will provide the aging person with a reflective mirror whose effects are numerous. First, it works to bridge the social gap between generations, which is important for the carrying on of culture and the continued moral education of the community. Second, the intergenerational relationship in and of itself provides meaning and purpose for the aging individual whose later years are more commonly associated with loss than gain. Third, engagement with younger persons can aid in the aging person's process of reflection by reminding him or her of earlier times in one's life and bringing to the fore the good and bad one has done as the process of a life review commences. For the younger person, he or she is exposed to the wisdom of the aging and learns how to offer care to those who have spent their lives caring for others. Encouraging the interaction between younger and older persons in society is a common theme in today's theological dialogue. Fostering intergenerational relationships, and the principle of intergenerational solidarity will be

explored more closely in Chapter Five, but recent official statements from the Catholic Church do more than only address intergenerational relationships. Recent works offer a fragmented outline of valuable elements of the aging process and what an individual might do live well.

While the Catholic Church does not offer a singular *official* position on aging persons, a number of statements from popes and the United States Conference of Catholic Bishops (USCCB) have been issued. John Paul II's 1999 letter "To the Elderly," was inspired by the late pope's own experience with advancing in years. He reminds aging persons that the difficulties experienced in the finite life we live are but part of our earthly existence, and work to help individuals grow and develop rather than diminish the good offered by earthly life. The ability to look beyond the obstacles of growing older is rooted in the belief that "we will survive beyond death itself,"⁴⁷ and that "God always gives us grace and strength to unite ourselves with greater love to the sacrifice of God's Son and to share every more fully in the plan of salvation."⁴⁸ Following in the religio-spiritual footsteps of both Richard and Nouwen, John Paul II reminds Christians that "the correct perspective is that of eternity, for which life at every phase is a meaningful preparation."⁴⁹ However, the pope adds an important element to his message: the inherent value of growing into old age. Instead of only outlining the hope of the Christian faith and its possible benefits for the aging person seeking fulfillment in later life, John Paul II offers a counter-narrative to an increasingly ageist culture.

As one progresses through the various stages of life, John Paul II explains, one experiences commensurate seasons of life. The Third Age, or Autumn as he describes it, is a

⁴⁷ John Paul II. "Letter of His Holiness Pope John Paul II To the Elderly." 1999. §2.

⁴⁸ John Paul II, "To the Elderly," §13.

⁴⁹ John Paul II, "To the Elderly," §9

time during which the well-experienced aging person shares his or her wisdom with others within and outside of that period of life. Continuing that wisdom is one of the many signs of divine favor bestowed upon the aging person in Scripture, the pope suggests that just as aging represents an opportunity to share wisdom with others, it is a time in which the bonds across generations can be strengthened – a period during which all members of the community can come together in solidarity. Building upon Richard’s belief that interdependence or mutual dependence is central to the experience of human life and serves a unique relevant to aging persons, John Paul II argues that interdependence serves both the older and younger persons of a community while placing a threefold duty upon the younger individuals so as to bring about fuller “enrichment from the gifts and charisms of all.”⁵⁰ That duty is based on the commandment to honor one’s father and mother, and thus it asks younger persons to 1) welcome older people, 2) help older people, and 3) make good use of older people’s qualities.⁵¹ The practicing of these unspecified duties is meant to lead to the reversal of cultural trends that marginalize older people or make them feel as though their lives are not worthy of dignity.

However, John Paul II does not offer the type of robust description of the dignified life that the faithful may have expected. He commends social programs aimed at keeping older people healthy and involved in their community, but the praise is always connected to older persons making “themselves useful” and putting “their time, talents and experience at the service of others.”⁵² The value in aging appears to be contingent upon one’s ability to contribute to the

⁵⁰ John Paul II, “To the Elderly,” §10.

⁵¹ John Paul II, “To the Elderly,” §11.

⁵² John Paul II, “To the Elderly,” §16.

society with society having some tangential and nondescript role in making such participation possible. This sentiment is reiterated in a short statement delivered to the World Assembly of Aging 2002, in which John Paul II warns that the aging not be understood as a burden to society, but rather viewed as “a resource which can contribute to society’s well-being.”⁵³ Likewise, Pope Benedict XVI claims that the intergenerational conversation spurs human growth and education because of the aging population’s diverse experiences,⁵⁴ but again places the emphasis on what the aging individual can do for others. For both recent popes, aging persons are made to be useful to the next generation whose interaction with the aging is interpreted as mutually beneficial – the wisdom transmitted is viewed as good, and the interaction itself is good for the aging persons because “no one can live alone and without help; the human being is relational.”⁵⁵ The USCCB echoes the notion that meaning is most readily found in being of service to others, noting the aging “have the opportunity to give something back.”⁵⁶ Contributing to the Church and to the larger community will enrich the life of the aging person. However, the opportunity to serve others is not necessarily an opportunity for self-expression in pursuit of the good life so much as it is a requirement stipulated by the USCCB: “older persons have a responsibility, commensurate with health, abilities, and other obligations, to undertake some form of service to others.”⁵⁷ Regardless of the elevated status and role of aging persons in Scripture, both the recent popes and USCCB tend to view aging persons in terms of their productivity within the Church

⁵³ John Paul II. “Letter of John Paul II To the President of the Second World Assembly on Ageing.” 2002.

⁵⁴ Benedict XVI. “Visit to the Community of Sant’Egidio’s Home for the Elderly ‘Vivi Gli Anziani.’” 2012.

⁵⁵ Benedict XVI, “Vivi Gli Anziani.”

⁵⁶ United States Conference of Catholic Bishops. “Blessings of Age.” 1999.

⁵⁷ United States Conference of Catholic Bishops. “Blessings of Age.” 1999.

community without much specific attention to how they might live well beyond such contributions. That is not to say that it is the responsibility of the Church to advocate for vacations and golf outings, or other stereotypical leisure activities associated with retirement; however, it is curious that retirement-aged persons are looked to as contributors within the Church given consumer culture's suggestions regarding productivity and worth and retirement being a time of not being productive.

In placing a demand upon the aging, the voices of the Church tacitly support cultural stereotypes and practices against which they claim to argue. Society tends to view the would-be aging persons vis-à-vis productivity as useless, perhaps even as freeloaders. No longer contributing to the economic production of society and shifting to patterns of consumption linked to an increasing level of dependence, aging persons can fall into socially constructed narratives about being burdensome or offering very little (economic) contribution to the fabric of society. Catholic voices recognize this socio-cultural problem and ask that it be reversed; however, each of the aforementioned documents begins with the assumptions that older people are frail, dependent, and otherwise lacking a purpose in society. The latter element, purposefulness, is what the Church turns to as the existential problem faced by aging persons. If the primary way to age well is through service to others, the Church's response to aging well is not all that dissimilar from other functional-productive approaches to aging well. Of course, aging persons are to be treated with dignity, an idea to be explored below and again in Chapters Four and Five, but there remains an obligation to be productive in order to age well. Such an approach from the Church demonstrates, albeit subtly, the pervasive nature of the functional-productive cultural narratives addressed in chapters one and two: one's value, one's good life is always connected to what one is capable of and actually contributing to the community or society. Surely, the Church does not

oblige those who are incapable of serving others to do so, but the expectation remains that if one is functionally healthy he or she must serve in order to age well. Being able to serve, or the capacity to serve points to a type of freedom that is important for an ethics of aging, and this freedom will be explored below; however, it is the seemingly quick answer to finding meaning in aging that the Church provides in obliging service to others that is disquieting. Instead of reversing the effects of the ageist trends in modern culture, the Church's attempts at reinvigorating Christian hope and faith in aging mask its tacit acceptance of shortsighted cultural narratives about Third Agers.

Moreover, the Church's focus on the usefulness of aging persons points to the acceptance of yet another ageist-inducing narrative. The interpretive lens through which the Church has viewed the aging process and aging persons is the assumption that aging always means physical and mental decline, or a general state of frailty. Present within each of the documents mentioned above are phrases like: "The signs of human frailty,"⁵⁸ "physical and mental deterioration,"⁵⁹ "old age is a season of life in which individuals are victims of human frailty,"⁶⁰ "very often, the onset of chronic illness incapacitates the old person and serves as an inevitable reminder of life's end,"⁶¹ "problems and limitations of this age,"⁶² "the diminishment of the senses"⁶³ "changes later in life involve losses...you probably worry about a decline and eventual loss of your own

⁵⁸ John Paul II, "To the Elderly," §10.

⁵⁹ John Paul II, "Second World Assembly on Ageing."

⁶⁰ John Paul II, "Second World Assembly on Ageing."

⁶¹ John Paul II, "Second World Assembly on Ageing."

⁶² Benedict XVI, "Vivi Gli Anziani."

⁶³ United States Conference of Catholic Bishops. "Blessings of Age." 1999.

personal health,”⁶⁴ all of which suggest that the general consensus of the Catholic Church is that aging is invariably linked to physical and mental decline, illness, dependence, and a general state of despair. Adopting the popular “aging as disease” line of thinking undermines the Church’s mission to be more inclusive; holding such a perspective, intentionally or not, validates the beliefs of those in the ‘aging as disease’ school of thought and their adherents who are often responsible for the perpetuation of ageist social, economic, and cultural trends. In other words, the Church’s position both limits its conceptual framework for the good life in aging and tacitly endorses the various elements that have led to the marginalization of the aging.

Furthermore, theological voices⁶⁵ can also succumb to the problem found in biomedical ethics – connecting aging to end-of-life care. An exemplary text is Allen Verhey’s *The Christian Art of Dying*, which, as its title would suggest, articulates a modern *ars moriendi*. He recalls the tension between religion and medicine that emerged during the era of Francis Bacon that can be seen today in the questions arising in medical technologies. “Medicine needs the church not only to limit and challenge the Promethean triumphalism of the Baconian project” urges Verhey, “but also to sustain its vocation not only to preserve life but also to care for the dying.”⁶⁶ How that is to be done, however, limits the role the Christian faith might have in addressing how one might

⁶⁴ United States Conference of Catholic Bishops. “Blessings of Age.” 1999.

⁶⁵ Other commentators who argue that the aging are in need of a normative framework for dying well in the modern age are Dugdale, Lydia. 2010. *The art of dying well*. Hastings Center Report 40 (6): 22-4; Speerstra, Karen and Herbert Anderson. 2014. *The divine art of dying well: how to live well while dying*.; Vogt, Christopher P. 2004. “Practicing patience, compassion, and hope at the end of life: mining the passion of Jesus in Luke for a Christian model of dying well.” *Journal of the Society of Christian Ethics* 24, no. 1: 135-138; Jones, L. Gregory. 2006. “Dying well.” *The Christian Century* 123, no. 9: 37. Of particular note is the following remark from Dugdale, representative of the problem in bioethics is her remark, “this [an individual’s, family’s, and society’s preparedness for death] is the challenge for bioethicists in the decades ahead: to create a framework for teaching an aging population to prepare for death and to support one another through the dying process.” *The art of dying well*. Hastings Center Report 40 (6): 23

⁶⁶ Verhey, Allen. *The Christian art of dying: learning from Jesus*. (Grand Rapids: Wm. B Eerdmans. 2011), 73.

age well rather than die well. Faith, hope, patience, humility, and letting go are described as virtues to be practiced by the dying person so as to mitigate the meaninglessness, uselessness, and total dependence one might view as burdensome in the dying process – the same socially constructed problems inherent in the experience known as aging.⁶⁷ Practiced by the aging Christian, these virtues mark the foundations of Verhey’s modern *ars moriendi*. The faith about which Verhey speaks is similar to the faith in the resurrection outlined by Richard – a faith that “is displayed in delight in God and in the fits of God, which include this world and this embodied life, and in confidence that the limits of that life God can still be trusted to care and save.”⁶⁸ Echoing Richard once again, Verhey highlights the importance of the Christian’s hope in the death and resurrection of Christ in which Christians learn of God’s power and purpose to offer salvation to humanity. Patience in dying well derives from Christ’s love exemplified in Scripture in which Jesus humbly accepted the suffering that befell him and continued to show love and compassion for the other. The humility of the dying Christian stands in the face of the pride demonstrated by those who might tend to value autonomy and control over the natural progression of dying. As a virtue, humility tempers the would-be hubris of an individual and reminds him or her that humans are and always will be vulnerable and contingent. Verhey describes letting go as consisting of “words of gratitude and praise, requests for forgiveness and the granting of forgiveness, provision for their [those with whom the dying have relationships] future wellbeing, and words of love and affection.”⁶⁹ Thus letting go enables the dying individual to make peace and bring closure to one’s life, but not discard others with whom one has

⁶⁷ Verhey, *The Christian Art of Dying*, 146-156.

⁶⁸ Verhey, *The Christian Art of Dying*, 148.

⁶⁹ Verhey, *The Christian Art of Dying*, 154-155.

relationships to ‘make it easier’ once death arrives. Taken together, these virtues, adopted from the *Ars Moriendi* of the 15th century, work together to provide comfort and balance to the individual as he or she moves closer to the end of life (i.e. the terminally ill patient). As helpful as this model of virtuous living may be for the dying person, it is still not a theology or ethic catered toward the aging members of the Christian community. Faith, a patient love, hope, humility in the face of God, and the ability to make peace with this life are not virtues exclusively relevant to those who imminently confront mortality. Accepting the challenge outlined by recent popes and the USCCB, incorporating the theology of aging conceived by Richard, and adapting the virtues to be practiced in the face of death, Edward Vacek SJ moves toward specifically addressing the members of the Third Age.

Aging And The Virtues

Critical of gerontologists who “usually avoid normative claims,”⁷⁰ Edward Vacek offers a vision for the aging that attempts address the Third Age’s ethical significance more directly than previous approaches. His concern arises out of the impending influx of retirement-aged individuals based on the historic size of the Baby Boomer generation itself, and from current trends in longevity improvement among Americans. Vacek’s two-pronged approach begins by addressing four moral priorities of old age as proposed by gerontologists and later turns to virtues as “habits appropriate for good human living.”⁷¹

Continuity, new beginnings, disengagement, and completion: each priority addresses particular aspects of aging, with an emphasis on each priority proportionate to the phases of the

⁷⁰ Vacek, Edward Collins. 2010. “Vices and virtues of old-age retirement.” *Journal of the Society of Christian Ethics* 30 (1): 161.

⁷¹ Vacek, “Virtues and Vices,” 166.

aging process. Vacek suggests that continuity and new beginnings are primary during the earlier stages of old age, the Third Age, while the other two find their immediate relevance closer to an age where the end-of-life looms larger. Continuity is a priority for the aging so that they persist in fulfilling moral duties they have had during earlier stages of life. Divorcing oneself from moral responsibility to family, friends, the community, is not an option for the aging person who is “required right to the last breath” to “love God, others, ourselves, and our world.”⁷² Simply because the aging individual no longer has a job to report to or a grandchild for whom to care does not release him or her from the bounds of moral responsibility. One such responsibility is that of continuing to work while one is healthy. As an expression of being a co-creator with God, producing goods for oneself and others is a “contribution to the world’s salvation.”⁷³ Continuing in the workforce will require a rethinking of economic and social policies regarding retirement, but aging persons should begin to believe that there is value in working after the requisite retirement age and that to arrive at that age does not mean that one is no longer capable of working. Implicit in Vacek’s notion of work is the idea that aging persons cannot and should not retire from religion. Faith and hope, he suggests, remind the aging person that everything he or she has done, does, and will do, will ultimately “be taken up into God and thus will never cease to be.”⁷⁴ In order to make the satisfaction of these duties possible the aging person must care for his or her body – the body will not take care of itself – the aging person is responsible for his or her health in this regard. Acting on moral obligations is contingent upon the body being biologically capable of fulfilling them. Presuming that the body does not respond or recover as it

⁷² Vacek, “Virtues and Vices,” 164.

⁷³ Vacek, “Virtues and Vices,” 164.

⁷⁴ Vacek, “Virtues and Vices,” 164.

once did in the later years, it is incumbent upon the aging person to exercise and maintain a proper diet. Vacek identifies new beginnings as a progression of continuity insofar as the gradual change accepted in continuity is interpreted and experienced as new ways in which the aging person can be active, physically cognitively or socially, ways in which the aging person can continue to be reinvented.

Being a developmental period of change and reinvention, according to gerontologists, the Third Age provides aging persons with an opportunity to invent and reinvent themselves by directing their time and energy into new personal or social activities.⁷⁵ Inventing and reinventing the self is part and parcel of loving the self and others; only when an individual continues to grow and adapt can he or she respond rightly to the other. However, specific ways in which one can progress, outside of “gardening, politics, the arts, or church outreach”⁷⁶ evade gerontologists, and, as Vacek laments, Christians. While “elderhood,” as Vacek calls it, should be an opportune period in one’s life to further explore and deepen one’s relationship with God, “church attendance actually is declining among the elderly” because “Christians have not sufficiently reflected on what this elderly spirituality might be.”⁷⁷ Still, as a proposed priority of aging the opportunity for new beginnings remains important as it has been shown that aging persons are in need of new avenues of fulfillment, regardless of how that need is socially constructed or culturally perpetuated. A new start in pursuit of aging well resulting from the “intellectual, economic, and physical resources”⁷⁸ afforded to aging persons requires that Third Agers learn to

⁷⁵ Vacek, “Virtues and Vices,” 165.

⁷⁶ Vacek, “Virtues and Vices,” 165.

⁷⁷ Vacek, “Virtues and Vices,” 165.

⁷⁸ Vacek, “Virtues and Vices,” 168.

accept what gerontologists say will come with disengagement and be made aware of the benefits of going through the process of completion. Once the aging person conscientiously decided that he or she wishes to age well, achieving the good life in aging is made possible. However, more practical guidance is needed.

In light of the moral priorities of aging, Vacek suggests that living the good life will require the practice of specific virtues. He admits that those virtues one has cultivated during earlier stages of development may no longer be appropriate during the Third Age, that what once served an individual well in his or her 40s will no longer provide the same type of balance regarding movement toward the good life given the new context of retirement. Continuity will require the habit of integrity while new beginnings will ask the aging person to move away from self-gratification and instead practice generosity. Humility and repentance help the aging person disengage constructively. They create the space in which the aging person can practice the virtues of trust and detachment in the pursuit of the good life.

The virtue of integrity helps to fulfill the priority of continuity in old age difficulties concerning the multidirectional changes occurring during the transition into and further development within the Third Age. Maintaining coherence between “one’s principles and norms”⁷⁹ is offered by Vacek as an important but not “strictly necessary” way of conceptualizing integrity; instead of trying to import a fixed set of values into a new era of one’s life, one should realize that just as one has developed wrong ideas that are incompatible with aging there might also be right ideas that are met with challenges in the later years. Thus, complete coherence from one stage of life to another is not the type of integrity that should be sought, but rather an

⁷⁹ Vacek, “Virtues and Vices,” 167.

integrity of the person that maintains the unity of both the body and soul.⁸⁰ The task of maintaining unity can provide a purpose to those who have lost a sense of purpose, which, according to Vacek, can be fulfilled by the theological virtues. While the frivolities of instant gratification become increasingly meaningless and less satisfactory, the hope in God's salvific plan can provide ultimate purpose. Vacek echoes Richard, John Paul II and Benedict XVI in his appeals to faith and hope, virtues he believes capable of providing the right meaning for Third Agers seeking to live well. Though featured prominently in Vacek's approach, it is unclear how faith and hope will practically lead the aging individual to the good life beyond an inherent spiritual satisfaction and comfort.⁸¹ Perhaps a complementary discovery of new activities will provide stability in one area of an aging person's life, allowing for spiritual integrity to be built upon a better, well established foundation.

One of the primary ways in which aging persons are told to spend their time and money during retirement is on socially constructed images of self-improvement. Simply because social policies and cultural norms facilitate and encourage the value afforded by various self-improvement activities (i.e. cosmetic surgery, acquisition of material goods), the good life cannot be reduced as such. To combat the attraction of self-gratification in aging, Vacek suggests the virtue of generosity. For Christians, the Third Age should provide a new context in which one can be of service to others, not only financially but also through active involvement in the community. This requires that aging persons move beyond the desire to only take care of

⁸⁰ Vacek, "Virtues and Vices," 167.

⁸¹ The inherent spiritual satisfaction is termed rest by Augustine in *Confessions*: "You stir man to take pleasure in praising you because you have made us for yourself, and our heart is restless until it rests in you." Augustine. *The Confessions*. trans Henry Chadwick. (Oxford: Oxford University Press, 1991), 3. This Augustinian theme informs Nouwen's use of *kenosis* in his approach to aging for it is only when one gives oneself over entirely to God that one can experience the totality of the good.

themselves and realize that their actions do in fact have implications for the future: “each of us comes into a world that has been prepared for us by our predecessors,”⁸² and the aging have a moral responsibility to prepare their world for those who will follow. This may come by way of philanthropic endeavors such as donating to charities, sharing one’s wisdom with younger persons in community gatherings, or serving the Church community in varying roles. Understood in this light, generosity resembles an act of intergenerational justice and teaches others a valuable lesson in gratitude. Recognizing that one is connected to others and that one’s actions have casual links to the fulfilment of the good life for the aging agent and future generations should work to inspire the type of generosity about which Vacek speaks. New activities in the Third Age naturally raise the question of how such engagement fits alongside the third moral priority of aging, disengagement.

Practicing repentance and humility are important for aging persons as they move into life’s later stages. As a virtue in aging, repentance asks the individual to both seek and offer forgiveness. For the Christian, such self-examination is part of one’s daily faith life (or at least should be), but it remains “a common feature of contemporary life that many people think of themselves as without much sin, at least as any felt need to repent.”⁸³ The trouble is that aging persons, according to those who work with them, fall into the group that do not find much need to seek or give such forgiveness.⁸⁴ Vacek attributes this primarily to aging persons, and perhaps contemporary culture, being ignorant of sinful behavior and in need of a crash course in what

⁸² Vacek, “Virtues and Vices,” 169.

⁸³ Vacek, “Virtues and Vices,” 170.

⁸⁴ Vacek, “Virtues and Vices,” 170.

everyday thoughts, words, and actions are sinful in and of themselves or indicative of being in a state of sin.⁸⁵ While such an endeavor may prove beneficial for aging persons, it is hard to determine whether aging persons who already show some signs of being unwilling to accept moral failures would be receptive to a modernized age-specific penitential manual. Regardless, the belief that aging persons need to acknowledge their own shortcomings and genuinely apologize for them and offer an equally sincere absolution to those by whom they have been wronged is an important step in transforming the aging subject “through grace into persons who would no longer sin, or at least, who hope they would no longer commit the sin.”⁸⁶ The transformation not only helps individuals let go of the past and detach themselves from the bad while they pursue the good life in aging, but also sets them up for another important virtue in aging, humility.

Admitting weakness in both the forms of sin and of one’s own unwillingness to forgive begins the practice of humility for the aging person. Humility first requires that aging persons recognize that they are not entirely self-made, as some very proud individuals may believe. The product of a given social environment, the aging person is indebted to the opportunities, both earned and unearned, that one has been afforded. That sometimes-jarring recognition takes on a new meaning when one is confronted by a body that begins to fail, a mind that slowly

⁸⁵ In addition to the possibility of aging persons, or many others in contemporary culture, not being aware of sin, it is important to note how that very notion affects Vacek’s overall assessment of the virtues and the broader communitarian philosophical model in which they might operate. Unaccounted for is the potential for ‘bad’ or ‘immoral’ practices to be inculcated; education in virtue does not automatically yield the ‘right’ decision or action. If an individual is unaware of sin, it is possible that he or she might not be aware of the types of bad dispositions one might have, that when brought into a pluralistic culture, are further complicated.

⁸⁶ Vacek, “Virtues and Vices,” 171.

diminishes, or by the loss of authority one used to have over the workplace home or the self.⁸⁷

Vacek summarizes what necessitates the virtue of humility:

Seniors have to humbly admit that they are not what they once were and they will never become what they could have become...they have to face the fact that they are no longer (as) necessary in the lives of people who once considered them central...they have to acknowledge that in all likelihood they have already made their most meaningful contributions to history.⁸⁸

When practiced diligently, humility can further open one up to God's grace by making the aging person both aware and accepting of one's dependence (which may become increasingly literal).

Despite the cultural narrative, accepting that one may be dependent in aging is not meant to be demoralizing; instead it is to be, as Richard suggested, liberating in light of God's promise.

Denying one's contingency, one's mortality, by opting for medical procedures that only serve to delay death is a response to the values espoused by American society and not by the Christian faith.⁸⁹ Vacek, like Callahan, does not suggest that accepting one's mortality means not taking care of oneself (see continuity above), but rather that the accepting one's finitude provides the appropriate perspective as one tries to age well. After recognizing one's limitations and

⁸⁷ Vacek, "Virtues and Vices," 171-72.

⁸⁸ Vacek, "Virtues and Vices," 172.

⁸⁹ Richard McCormick SJ identified "the denial of mortality" as an influential value variable in bioethical thought. He argued that this and other value variables in bioethical thought and health care planning "can be profoundly influenced by certain cultural assumptions, trends, unexamined attitudes, [and] biases." In general, denying mortality means exhausting all possible medical interventions regardless of their ability to cure the underlying pathology, their cost, or the quality of life they could promise. McCormick, Richard. *Corrective Vision: Explorations in moral theology*. (Kansas City: Sheed & Ward, 1994), 165-6. In the broader theological context, McCormick argues that this denial of mortality is antithetical to the core of the Christian faith. Life, he explains, is a basic, but not an absolute good. "It is basic because, as the Congregation for the Doctrine of the Faith worded it, it is the 'necessary source and condition of every human activity and of all society.' It is not absolute because there are higher goods for which life can be sacrificed (glory of God, salvation of souls, service of others, etc.)." See McCormick, *Corrective Vision*, 146.

practicing humility in the face of the “humiliations”⁹⁰ of old age, the aging person must accept that his or her vulnerability involves trust, a trust that is unique to this particular developmental period.

Practicing trust in the Third Age and beyond asks that the aging person surrender oneself to others and to God. However, trust in aging, particularly in the face of death, is made difficult by the loss of autonomy, uneasiness about our own contingency, and a fear of death. Trust and its impediments in aging are representative of Vacek’s entire project – the preceding three moral priorities and requisite virtues are summarized by a fundamental trust that enables the individual to age well. As a moral priority in aging, continuity means trusting that there can be a new purpose found in the Third age. Disengagement⁹¹ requires that aging persons trust that their limitations are acceptable and do not diminish their being, and completion asks aging persons to trust that life has been completed well. That trust is really faith, faith in the Christian God who will take care of the aging person, who will usher the aging person into the next life, and who will remain with the person throughout eternity. Within a culture that promotes independence and self-sufficiency, and facilitates those values by way of “social security, retirement accounts,

⁹⁰ Vacek, “Virtues and Vices,” 172.

⁹¹ What Vacek terms disengagement must be kept separate from formal disengagement theory. Vacek notes that the experience of aging may come with a certain level of loneliness as one loses friends, loved ones, or that one may be forced to be ‘lonely’ as a result of physical or cognitive decline. Though these experiences are not desirable, they sometimes provide “more space for reflecting on the self that we have become,” and remind the self that there is more to life than the attachments of this life. Disengaging resonates with much of what Tornstam’s gerotranscendent model addresses. The priority of completion is based on what gerontologists note as a process involving attention to an integrated life story that has does indeed have an end in sight. Gerontologists believe that stitching the narrative of one’s life together can enable aging persons to resolve prior conflicts or repair relationships, or generally provide a framework for making sense of what has happened, is happening, and will happen. The backward and forward look made creates the space in which attentive to the past can influence how one acts in the present, and thereby reconfigure the past, in an attempt to believe one has lived a satisfactory if not good life throughout, not only in aging.

and government sponsored savings plans,”⁹² trusting fully, however, is exceptionally difficult. Social security benefits are not nearly enough to facilitate a comfortable independent life, and retirement accounts are largely determined by forces outside of the contributor’s wanting to save more for retirement. Living the type of independent life of advertising campaigns and television is not the most plausible of scenarios for many retirees, but the kind of spiritual independence espoused by Vacek is different in nature. The independence achieved through trust or faith is the kind that allows the aging person to more fully let go and detach him or herself “from their important life-long practices of constructing a symphony of meaning out of the booming, buzzing cacophony of life’s sound” and instead “rely on God’s ‘silent music’ that has been playing in the background through their entire lives.”⁹³ As both the beginning and end of Vacek’s vision for the good life in aging, practicing trust enables aging persons to use this stage of life productively and contemplatively.⁹⁴ Taken together, Vacek’s virtues, implicitly and explicitly contingent upon a profound Christian faith, identify the good life in aging as the result of a series of transitions that require prudential reinterpretation and re-appropriation of previously held and practiced values. In short, the good life in aging is achieved by the individual who is capable of discerning how the Third Age can be a positive and fulfilling experience in the face of narratives that would suggest otherwise.

In addition to the virtues of the ethics of aging outlined by Vacek, other theologians, namely Charles Pinches and Stanley Hauerwas, offer their own virtues whose practice also promises to lead to the good life in aging. Pinches affirms Vacek’s concern that the virtues to be

⁹² Vacek, “Virtues and Vices,” 173.

⁹³ Vacek, “Virtues and Vices,” 174.

⁹⁴ Vacek, “Virtues and Vices,” 174.

practiced in aging are not one size fits all in terms of the specific time in which they become relevant and how each individual will adopt and practice a given virtue, and that the aging person is indeed capable of showing others what the good life is all about.⁹⁵ Admiring the beauty of God's creation, the aging person can practice the virtues of simplicity and delight. In appreciating that which surrounds the aging person, Pinches believes that the appreciation will materialize into an act that engages the individual with others, whether they be intra-generational friends, grandchildren, or family members.⁹⁶ Such acts will inspire another virtuous practice, empathy, in which the Third Ager transcends one's own needs and takes a wholehearted interest in the wellbeing of the other. Like Vacek and those before him, however, Pinches' suggested virtues are only useful for the aging insofar as they are grounded in the theological virtues: faith, hope, and love – once again, the faith and hope of the Christian are most important in making possible and orienting other the requisite virtues for the good life. Though he explicitly reminds aging persons not to become fixated with faith and hope to the extent that mortality is always first and foremost on the mind of individuals, it is impossible to say that Pinches' approach does anything beyond demanding the aging Christian to be even more faithful, if that is possible, so as to enable the individual's living the good life.⁹⁷ Working within a virtues framework for much of his own theological ethics, Hauerwas' articulation of what he calls the virtue of friendship offers

⁹⁵ Charles Pinches. "The Virtues of Aging," in *Growing Old in Christ*, ed. Stanley Hauerwas et al. (Grand Rapids: Wm. B Eerdmans Publishing Co, 2003), 202-204.

⁹⁶ Pinches, "The Virtues of Aging," 211.

⁹⁷ Pinches's own vision of the good life is informed by the virtues tradition within Christian ethics born out of Aquinas's interpretation of Aristotle's *Nicomachean Ethics*. The good life, or happy life, is one lived virtuously. Exemplary virtues for Pinches include: hope, obedience, courage, and patience. See: Hauerwas, Stanley and Charles Pinches. *Christians Among the Virtues: Theological conversations with ancient and modern ethics*. (South Bend: University of Notre Dame Press, 1997); and, Pinches, Charles. *Theology and Action: after theory in Christian ethics*. (Grand Rapids, MI: Wm. B. Eerdmans, 2002).

something a bit more substantive and tangible than the extensions-of-faith-type virtues outlined by others.

Couching Christian friendship in Aristotelian terms, Hauerwas believes that pleasure is intrinsic to friendship, and continues that friendship is found, understood, and expressed most fully in one's Christian community.⁹⁸ A Christian friendship that aids one in the acquisition and practice of Christian virtues, builds up the Christian community, and makes possible a friendship with God reveals to the aging person the gift of aging in the Christian community.⁹⁹ Maintaining friendships with the right people can reveal the good to the aging person and move him or her toward the good bound up with God. The friend and the aging individual inform the virtuous practice of one another and thereby reinforce each other's movement toward the good life, together. In this way friendship reminds the aging person of his or her need for relationships and begins to reveal, perhaps more gently than Vacek's approach, one's vulnerability and contingency in an innocuous manner. Friendships that are cross-generational provide the aging person with the opportunity to reflect on one's own experiences at a given age (that of the friend from a different younger generation) while also facilitating a mutually informative relationship that will ultimately help the entire community in its pursuit of the good life.¹⁰⁰ Authentic friendships among the aging enhance the Christian community by enmeshing the wholly present aging, who are often socially reduced to being best equipped to be present, with younger persons who are distracted and consumed by their daily goings-on, smartphones, or other outlets for

⁹⁸ Stanley Hauerwas and Laura Yordy. "Captured in Time: Friendship and Aging," in *Growing Old in Christ*, ed. Stanley Hauerwas et al. (Grand Rapids: Wm. B Eerdmans Publishing Co, 2003), 176.

⁹⁹ Hauerwas and Yordy, "Captured in Time," 176-177.

¹⁰⁰ Hauerwas and Yordy, "Captured in Time," 178.

instant gratification.¹⁰¹ Aging members of the Christian community remind their friends that Christianity is more about being than doing, a life exemplified by the aging person. Finally, friendship creates the opportunity for achieving the very purpose of the Christian person – a friendship with God. The experience of being friends with God is made possible through human friendships with others and with the self.¹⁰² Though the relationship is asymmetrical regarding humans' finitude and God's infinitude, friendship with God reminds the aging person of his or her vulnerability without making it the explicit starting point as others have suggested.

Acceptance of mortality is necessary so that one's friendship with God and one's self is honest, but in the context of a communal pursuit of the good comprised of individual friendships acknowledgement of one's contingency offers reassurance that one is moving toward the ultimate good and that one need not be anxious about what is to come.¹⁰³ Like other theological authors, Hauerwas's conception of Christian friendship eventually calls upon the aging person to acknowledge and accept mortality, and it is faith and hope that become central to aging well in the face of death. Love for the other, love for the self, and then love for God helps the individual to age well. But to whom is this uncomplicated act of turning to love available?

Throughout this section the authors have stressed the importance of the virtues, theological and intellectual, for the aging. Yet what remains unclear is to whom the authors are speaking. Turning to faith and being humble are certainly worthwhile practices as one ages, but faith and humility's ability to solve the aging person's problems assumes that the only problems the he or she faces are how to balance one's relationships with God and others. A presumption of

¹⁰¹ Hauerwas and Yordy, "Captured in Time," 180.

¹⁰² Hauerwas and Yordy, "Captured in Time," 180.

¹⁰³ Hauerwas and Yordy, "Captured in Time," 181.

the affluent Baby Boomer is explicitly made in Vacek, but he does not say how his virtues are capable of transcending socioeconomic status. Practicing generosity will be quite difficult for the aging woman who has suffered from inequality in pay throughout her life and must continue to work through the Third Age to support herself; she cannot afford to be generous with her money or time. The aging person who has been poor may not possess the means necessary to participate in the type of fulfilling friendships outlined by Hauerwas. An aging man in rural Iowa may not have the ability to maintain close relationships with friends and family, and thus becomes further dependent on social institutions to help him age well. Similarly, the sick underinsured aging person may not be enabled to stay healthy as she ages and never be given the choice to disengage and accept her limitations, despite how psychologically and spiritually important that may be. If she is able to disengage, she is still left with the question of how to practically age well beyond being committed to her relationship to God. Is a good part of her adult life meant to be one of isolation or simple devotion with the hopes that her earthly problems will resolve themselves? And worse, is the limited message she hears ‘accept your mortality’? It is difficult to assume that this is the conclusion intended, but the question remains, given the authors’ collective lack of attention to both the individual and social contexts in which aging takes place, and how their messages can be received. Needed are ways in which the virtues can be modeled in different settings so as to address the diversity of the aging population and its needs. One recent theological work emphasizes the importance of care within the community.

Moses' *Ethics and the Elderly: The Challenge of Long-Term Care* examines two models of communal care that address much of what has been outlined above as central to aging well. While the title may suggest that her concern is for members of the Fourth Age, Moses argues that the distinctions made between the Third and Fourth Ages are dubious. Further, she believes the distinctions do not adequately speak to the subjective experience of aging and only work to obfuscate the fundamental claim that aging persons are in need of and entitled to care.¹⁰⁵ Citing

¹⁰⁴ It is important to note here that the ethics of care is an important but distinct model that I choose to stay away from in this and the following chapter. I do so for several reasons. First, the ethics of care, when used in medical contexts, presumes the caretaker-caregiver relationship, which as the dissertation has shown, is subject to myths about all aging persons needing to be cared for regarding health concerns. It is necessary that the need for a medicalized notion of care not be identified as an essential characteristic of aging. Broadly speaking the ethics of care is important for an ethics of aging, but for the purpose of not perpetuating a popularly cultural or intuitive association, I have chosen to keep it separated from this foundational discussion. Second, the models of justice I will rely upon to inform my vision for an ethics of aging (chapters four and five) will come from the communitarian tradition of Alasdair MacIntyre, whose work on dependency offers the same type of attention to relationships of asymmetric dependence that an ethics of care does while continuing with the theological themes addressed in this chapter; Martha Nussbaum, whose capabilities approach to justice meshes well with the work of the feminist perspectives that inform an ethics of care regarding empowerment, access, disability, and equality; and Catholic Social Teaching, which considers, to the best of its ability, the entirety of the social context in which the individual lives, and offers proposals for improvement in areas of the economy and health care among many. Still, I do not want to be dismissive of an entire discipline that can help inform and be a continued conversation partner with an ethics of aging. Margaret Farley is but one theological voice within the ethics of care about whom it is worth sharing some words. In *Compassionate Respect*, Farley revives the relationship between compassion and respect using the normative framework of care ethics. She argues that compassion enables the caregiver to more effectively respond to the person in need by suffering with the person. Respecting the person in need refers to respect for "bodily structures, historical and cultural contexts, personal and institutional commitments, potential for many kinds of growth as well as actual maturation, individual and communal opportunities and responsibilities, failures and achievements, desires and hopes." [Farley, Margaret. *Compassionate Respect: A feminist approach to medical ethics and other questions*. (Mahwah, NJ: Paulist Press, 2002), 39]. The relevance of Farley's call for respect in this regard will become apparent in the fourth and fifth chapters, but it is evident that on this particular point, her work can be instructive in how to proceed in constructing an ethics of aging. However, it is in regards to compassion that concerns arise regarding assumptions about the aging. The suffering other is the stimulus for the type of care that she speaks about, and it is my concern that lumping aging and suffering together does more damage than good. However, as will be shown below, care does have a place in aging, but it must be spoken of very carefully so as to not unintentionally support social constructed imageries of aging that run counter to the potential for the good life in aging.

¹⁰⁵ Though I agree with much of Moses' assessment of the experience of aging and the futility of drawing concrete boundaries between stages of development/aging, it is important to stress rather than collapse the tension that exists between the needs of someone in the Fourth Age and his or her capacity for and conceptualization of the good life and that of someone in the Third Age. Frequent use of the word 'elderly' is symbolic of Moses's adopting culturally

the Sant'Egidio and Green House Project as exemplary models of care proven (on smaller scales) to be effective in manifesting the theologically rooted ethic of care, Moses offers a social action model for aging. Both Sant'Egidio and Project Green House are described as capable of invigorating “our moral imagination by demonstrating the practical possibility of caring for older people in a way that honors their dignity and promotes their ongoing agency.”¹⁰⁶ Thus the communitarian structure is not intended to undermine one’s autonomy; instead the work of the community is intended to foster the aging person’s agency. Because both models of care respond to the challenges posed by social, cultural, political, medical, and even religious forces that can impede aging well, Moses’ appeal to both is instructive for how aging well can be facilitated. She is able to bridge the gap between faith and virtues by turning to a community that is mutually supportive and empowering. The models proposed provide a way forward for achieving the goals set out by both Richard and Vacek within the contexts outlined in chapters one and two. On the latter point, it is important to turn to one of Moses’ most important contributions to the discussion: that is, her discerning the role of autonomy for the aging person.

Moses maintains that the community is called to ultimately advance the aging person’s agency. She defines agency as “possessing the capacity for ongoing development and contribution, as having preferences and desires that correspond with one’s self-identity and life goals, and as capable of interpersonal relationships and exchange of affection and support,”¹⁰⁷

informed descriptors that oftentimes convey negative perceptions of the aging experience. Despite her championing the positive experience of aging the repeated phrase ‘long-term care’ conjures images of institutionalization and the medicalization of the dying process itself that imply aging as decline only.

¹⁰⁶ Moses, Sarah M. *Ethics and the elderly: the challenge of long-term care*. (Maryknoll: Orbis Books. 2015), 37.

¹⁰⁷ Moses, *Ethics and the Elderly*, 11.

and that such agency is to be practiced and affirmed in relationships with and even dependence upon others. Both Sant'Egidio and Project Green House are “shaped by a fundamental understanding of old age as a time of potential growth and development,”¹⁰⁸ which affirms the theological contributions considered above. Instead of disparaging dependence, these communities offer an alternative vision of dependence that empowers the aging person through continued social interaction with peers and younger persons, access to the medical care needed at various moments in the Third (and Fourth) Ages, and opportunities for genuine friendship born out of voluntariness. Perhaps understated by Moses, the voluntary¹⁰⁹ nature of participation in the Sant'Egidio community confers upon the aging person the very dignity and sense of worth that has been impeded by social and cultural norms that promote an absolutist autonomy and pathologize aging to the point of it inherently being an undignified developmental stage that is only understood as it relates to death. Quoting the founder, Andrea Riccardi, Moses highlights the link between the Gospel's call to serve the poor which becomes the mission of Sant'Egidio's ““everyday members”” who ““live in concrete solidarity with the poor.””¹¹⁰ The type of commitment involved on behalf of the volunteers and on the aging themselves who must give themselves over to such a model of living reinforces the idea that “the experience of dignity in old age is profoundly affected either positively or negatively by the attitudes and treatment of the larger community.”¹¹¹ One of the larger communities responsible for affirming the dignity of

¹⁰⁸ Moses, *Ethics and the Elderly*, 78.

¹⁰⁹ Moses, *Ethics and the Elderly*, 39. As she explains, “members of Sant'Egidio participate in the organization and activities in a voluntary, unpaid capacity, supporting themselves and their families with regular jobs.”

¹¹⁰ Moses, *Ethics and the Elderly*, 39. Andrea Riccardi. 1998. “Promoting Democracy, Peace, and Solidarity.” *Journal of Democracy* 9.4:157-67.

¹¹¹ Moses, *Ethics and the Elderly*, 170.

aging persons is the church.

Adapting a model of discipleship for aging well, Moses argues that it is incumbent upon the church to continuously and more vigorously affirm the dignity of aging persons. Important in counteracting the popular ‘aging as negative’ narrative is the church’s promotion of equality expressed through mutuality where mutuality is rooted in the Christian’s fundamental call to love and serve one another. The vocation to serve is an equalizer for Christians in that being a Christian, regardless of age or any other descriptor, carries “a mutual moral obligation to one another.”¹¹² As a result of this call to serve, being a Christian can and always does provide a purpose whether one is young or old. Such an established and unceasing purpose can mitigate the so-called burden of being a recipient of care in later life as the aging Christian can instead see oneself as the subject rather than object of care.¹¹³ However, it would be impossible to say that the aging individual will not sometimes feel like the object of care. In those moments, it is important that the church community works to enable aging persons to “respond to these demands as ways to contribute to the moral and spiritual growth of others.”¹¹⁴ How exactly that response directed toward others is to be both fulfilled and fulfilling remains difficult to articulate given the diversity of experiences of the aging. Thus, we return to the role the love of self plays in aging well.

Conclusion

The Christian theological tradition has presented us with a range of sources for the further development of an ethics of aging. The biblical literature demonstrates the positive value of

¹¹² Moses, *Ethics and the Elderly*, 116.

¹¹³ Moses, *Ethics and the Elderly*, 126.

¹¹⁴ Moses, *Ethics and the Elderly*, 127.

aging, both religiously and socially. The obligation to serve and contribute to society in the Third Age, addressed as problematic in the first and second chapters, returns in the Christian tradition. When it is upheld as a Christian duty, it is perhaps even more problematic. Part of the theological tradition tries to negotiate the problem of giving aging persons the freedom to do nothing and obliging them to do something, but the former is antithetical to the Christian faith as witnessed by Richard (and Metz) and the latter runs the risk of only seeing value in the aging person that contributes to the community. Yet, what the Scriptural and later theological traditions suggest is that life is lived well through the practice of virtues. The different virtues ethics explored in this chapter rely so heavily on the theological virtues of faith and hope that the practicing of any aging-specific virtue almost becomes secondary to them. This is the same problem addressed above regarding how theologians and ethicists have tried to negotiate between Metz's bourgeois and messianic Christianity in the context of the aging.

Part of the problem is that the virtues ethics approaches to aging presume a community of like-minded individuals, which the second chapter has shown is, at the very least, complicated by the American interpretation of individualistic autonomy. Despite the impediment posed by strong claims to autonomy as independence, Moses explores the success of Sant'Egidio communities for aging persons. Despite their efficacy, there are few Sant'Egidio communities. They are the exceptions rather than the norms.

The Christian tradition presumes an acceptance of communality that relies upon interdependence as a way of achieving the good life and that recognizes phases of dependence as opportunities to love and care for the other – and perhaps this is exactly the locus of the disconnect between Christian norms and American cultural values. If the question of independence and dependence is a primary impediment to conceptualizing and living the good

life in aging, then it is necessary to offer a counter-theory capable of firming up some of the foundational claims about community implicit or explicit in the Christian tradition. Virtuous living must be part of an ethics of aging, but the community-centered context for the success of a virtues approach requires that autonomy as independence be reconsidered. The next chapter will explore philosophical responses to the question of how to live well in the Third age, before we turn one again to the theological-ethical tradition, and a proposed framework for an ethics of aging.

CHAPTER FOUR

FLOURISHING IN THE THIRD AGE – DEPENDENCY

AND THE CAPABILITIES APPROACH

Introduction

The previous three chapters have surveyed various visions of aging well presented to Third Agers in modern America. The contributions of medicine and medical ethics, analyzed in Chapter One proved helpful in both identifying a standard of health and discussing how it is that those health metrics should be achieved. Gerontology focuses, in part, on the psychological development of aging persons. The problem, however, was that the ways in which aging and aging well was described in the first chapter optimal physical and mental functioning alone. Reducing the aging person to a functioning body and mind can have deleterious effects on a person's sense of self-worth, a problem explored in the second chapter. The exploration of the social contexts in which imageries of aging well are offered revealed that in America, the concept of the good life has always been inextricably linked to an individual's autonomy. Autonomy is indeed important, and preserving its place is necessary in constructing an ethics of aging. It is its interpretation within the American consumer context, however, that contributes to a detrimental influence on notions of aging well. The current consumer culture reveals the relationship between the functionality, productivity, and social valuation of the individual.

Productivity is the socio-economic analogue to the medical model of health of well-functioning body and mind.

As a potential corrective for an overemphasis on autonomy and the perceived lack thereof in the Third Age, Chapter Three turned to theology. The biblical sources grant the older members of society a sacred status and demand social obligations toward them, while the theological tradition emphasizes the positive contributions of the aging population to society. Reminding aging Christians of their unique capability to transmit the faith to the community and share their wisdom with younger generations is important, but an ethics of aging must be careful not to claim the value of aging is to be found in what one can do for others.

Theological scholarship of aging turns to the importance of faith in the aging process. The theological virtues of faith and hope are regarded as essential to aging well because of their ability to provide meaning to one's life. Such profound and transcendent meaning is capable of easing both the fears of and actual physical and/or mental decline by reminding the aging person of her or his relationship with God as being of ultimate importance and reaffirming one's ultimate purpose. Similar to Lars Tornstam's gerotranscendence model, faith and hope would involve moving beyond aging to a state of peace that allows one to more fully place one's life into perspective and live well in light of one's finitude. Using parts of the biblical and spiritual tradition, a virtues ethics approach emerged as a primary model for aging well in theological ethics.

Though faith and hope feature prominently in these virtues approaches, some models provide lists of adapted moral or intellectual virtues as well. Humility, generosity, and friendship serve to direct the aging person in his or her relationships with peers and non-Third Agers alike,

which are believed to be beneficial for the individual and the community. When taken together the virtues provide a vision of aging well that does not center on productivity. Instead, the virtues identify habits that are valuable *ad intra* (i.e. self-identity) and *ad extra* (i.e. public expression and recognition of self-identity and value). If, however, we take the virtues framework as being the most complete approach for living the good life in aging we are still faced with the problems of the cultural and social factors of Chapters One and Two that impede an aging person's ability to practice those virtues. Perhaps the most important cultural influence that hinders both an aging person's ability to envision and actualize the good life in aging, and skews society's perception of aging persons is the primacy of the liberal concept of autonomy, understood as individualistic independence. As was made clear in Chapter Two, the particularly individualistic interpretation of autonomy weighs heavily on what it means to age well, a problem that is reinforced by medicine, consumer culture, and some social policies. Needed then is alternative point of departure that does not view individualistic independence as essential to the good life (and American identity). In particular, an ethics of aging needs an approach that can address the fundamental condition of dependence experienced by all humans without threatening the autonomy of the individual. Because of the prominent place of autonomy in American culture and, more broadly, as a central value of modern (Western) culture, autonomy must be integral to the construction of an ethics of aging. After exploring Alasdair MacIntyre's philosophical approach that aims to solve the apparent conflict between autonomy and dependency in aging, I will turn to Martha Nussbaum's Capabilities Approach (CA) as a framework for constructing and ethics of aging.

Dependency, Autonomy, And Aging

Central to MacIntyre's perspective is that the good life, or human flourishing, is not at all possible if persons do not accept their natural state of vulnerability or dependence. The good life as flourishing is rooted in Aristotle's ethics, understood as the telos of human life, or *eudaimonia*, sometimes translated as happiness, welfare, or flourishing. *Eudaimonia* is also translated as the highest happiness, which is described as such because the individual seeks it for its own sake. Aristotle notes that there are goods in life that make one happy and are constitutive of the good life, but are subordinated to the highest good, living well. For example, health and wealth may be important in one's ability to and experience of flourishing, but alone do not constitute the fullness of flourishing. Living well is never a completed action; it is practiced and maintained through participation in those other goods that contribute to one's wellbeing. Such subordinate goods are those activities that provide the satisfaction of desires, or yield a happiness that is fulfilling but that does not bring about the state of *eudaimonia*. Without practicing or attaining lesser goods, *eudaimonia* would not be possible, but practicing lesser goods in and of themselves does not bring about *eudaimonia*. If our wellbeing is contingent upon being able to practice and participate in other goods, then it is fair to say that flourishing itself is dependent on various factors. Extending this idea to the individual and his or her flourishing, the individual's wellbeing is always dependent on externalities that make flourishing possible. With this in mind, debunking the myth that all individuals are "independent rational agents"¹ is the subject of MacIntyre's *Dependent Rational Animals*.

The task of overturning the popular belief that the human telos is to be or become an

¹ MacIntyre, Alasdair. *Dependent Rational Animals: Why human beings need the virtues*. Vol 20th ser.;20. (Chicago, IL: Open Court. 1999), 5.

independent rational agent, and the corollary claim that the good life is contingent upon one's independence, starts with MacIntyre's assertion that our dependency is an inescapable anthropological truth: for "it is most often to others that we owe our survival, let alone our flourishing, as we encounter bodily illness and injury, inadequate nutrition, mental defect and disturbance, and human aggression and neglect."² While one's dependency may not be experienced in the same exact ways throughout one's life, all persons live along a continuum of dependency.³ Lives are marked by moments of increased dependence as in the instances of those needing support, moments of unperceivable dependence when an individual does not recognize the role of others in his or her current state of flourishing, or moments in between when an individual appreciates the help of others in his or her success but continues to attribute success to individual effort. The successful adult businessperson does not necessarily need someone or something else to help him or her live the good life, but as a child that same person was very much dependent upon others to make sure that his or her wellbeing was ensured. Similarly, as individuals move beyond the middle years of life and into the Third Age they may begin to rely again more upon other persons or social institutions. MacIntyre goes so far as to say that any philosophy that does not start with this fundamental truth is not credible. Yet, being dependent is neither opposed to nor threatens individual autonomy. He turns to virtues to reveal how our autonomous decisions have always been contingent upon others, but first a discussion of MacIntyre's approach to dependence and vulnerability.⁴

² MacIntyre, *Dependent Rational Animals*, 1.

³ MacIntyre, *Dependent Rational Animals*, 1.

⁴ Though MacIntyre is not a feminist per se, his work in *Dependent Rational Animals* is clearly the fruit of the feminist philosophical tradition. To show his gratitude for this perspective, he dedicates almost an entire page of text to his influences on the questions of disability, vulnerability, and dependency, whom include: Eva Feder Kittay,

Reasserting human animality, suggests MacIntyre, can help to understand the essential human characteristics of dependence and vulnerability. By showing the ways in which humans are like some other intelligent animals, he works to break down the barrier created in philosophy that separates animals and humans into two distinct categories. Though there are important differences, placing humans and animals on a continuum rather than on distinct planes enables MacIntyre to look instructively to animals' dependence and abilities to act intelligently. He in turn focuses on Aristotle's *Metaphysics*, arguing that an overemphasis on rationality as that which separates humans from animals detaches humans from the fact that we are animals, too. However important the distinction between humans and animals is regarding reason, there is an important similarity that proves instructive in light of the emphasis on autonomy and independence.

Like all other animals, humans rely upon parents for basic needs such as food and shelter, and later upon others within the community for relevant social knowledge, i.e. "affections, sympathies, and inclinations."⁵ From birth one "is engaged in and defined by a set of social

Diana Tietjens Meyers, Julia Hanisberg and Sara Ruddick, Susan Wendell, and others. Most notably, he singles out Virginia Held and her work on the mother-child relationship as a "paradigm for moral relationship." MacIntyre, *Dependent Rational Animals*, 3. The use of MacIntyre instead of the feminist authors comes from MacIntyre's Aristotelian roots, which fit nicely with the chapter's second major thinker, Martha Nussbaum. Additionally, the choice of MacIntyre was intended to keep the beginnings of the constructive element away from, as best as possible, the aging-as-disease images that can be conjured up when one hears of an ethics of care. In building off of the feminist tradition without fully embracing an ethics of care, MacIntyre's thought presents a framework better suited for an ethics of aging compatible with the already existing communitarian and virtues approaches within the theological tradition. He is able to highlight the important of dependency and interdependency without contextualizing their significance in the communitarian approach as an ethic of care. For more commentary on MacIntyre's feminist influence, see: Joseph Dunne. 2002. "Ethics Revised: Flourishing as Vulnerable and Dependent. A critical notice of Alasdair MacIntyre's *Dependent Rational Animals*" *Journal of Philosophical Studies*, 10:3, 339-363. DOI: 10.1080/90672550210152159.

⁵ MacIntyre, *Dependent Rational Animals*, 121.

relationships which are not at all of her or his own making,”⁶ meaning that even though individuals may believe themselves to be independent, the individual choices that are made are and have always been informed by, sustained through, and in response to one’s interpersonal relationships and community. As the child is sustained and nourished by a mother during gestation and infancy, so, too, is the very person sustained by a matrix of influences.⁷ MacIntyre argues that the very independence to which individuals may appeal is never truly in the individual’s control. What it means to flourish or achieve the good life, though identified and pursued as one sees fit later in life, has already been imprinted on the individual who only later *determines* how he or she then wishes to achieve it. Virtues of acknowledged dependence, as MacIntyre calls them, are essential to any other virtues of independent rational agency, and “a failure to understand this is apt to obscure some features of rational agency,” like the problems resulting from an overemphasis or absolutization of autonomy. Both sets of virtues, independence and acknowledged dependence, are needed for understanding and achieving flourishing.

Like other intelligent animals capable of learning how to identify and pursue a series of goods under the guidance of a mother and/or other social grouping, humans learn what it means to flourish through structured social relationships operating at different stages of life.⁸ As an individual matures, he or she becomes increasingly aware of the requisite practices necessary to achieve the particular goods of a given developmental stage, and in achieving those goods

⁶ MacIntyre, *Dependent Rational Animals*, 74.

⁷ See Chapter Two, pp 76-77, regarding Pierre Bourdieu’s use of the term *habitus* and the matrix of perceptions one forms living in a given culture.

⁸ MacIntyre, *Dependent Rational Animals*, 63.

experiences some level of flourishing. Possessing the requisite social knowledge enables individuals to cooperate with others in the “pursuit of a shared goal,” where goal implies a specific reason, and that reason is the inherent good of the goal being achieved.⁹ The goods themselves are to be pursued by specific activities, which are inherently satisfactory and contribute the individual’s wellbeing.¹⁰ Fulfilling those goods is what it means to flourish, where flourishing requires the “distinctive powers that it possesses *qua* member of that species.”¹¹ The ‘good’ is explained in three different ways: something generally good for all persons, good for persons in specific situations, and to be good at a particular practice or skill.¹² These different understandings work synergistically; thus it is in the identification of the goods requisite for flourishing that the individual comes to realize how influential one’s dependency has been in learning those practices that bring about the good life. As an infant directs him or herself, albeit involuntarily, toward the fulfilling of bodily desires, the infant both experiences and learns the fruits of purposive action directed toward a given good. “The achievement of goods, and in taking notice of it” helps the child to understand the satisfaction of individual goods and later begin to explore a “wider range of kinds of good.”¹³ It is in the discerning process associated with understanding the wider range of kinds of goods that more completely satisfies particular desires in particular situations that the developing independent moral reasoner¹⁴ may begin to

⁹ MacIntyre, *Dependent Rational Animals*, 24.

¹⁰ MacIntyre, *Dependent Rational Animals*, 63-64.

¹¹ MacIntyre, *Dependent Rational Animals*, 64.

¹² MacIntyre, *Dependent Rational Animals*, 65.

¹³ MacIntyre, *Dependent Rational Animals*, 68.

¹⁴ MacIntyre, *Dependent Rational Animals*, 83. The independent practical or moral reasoner is one who has learned to “evaluate, modify, or reject our own practical judgments, to ask whether what we take to be good reasons for

realize the influence of others when he or she asks the question ‘what is good for me,’ or ‘what is best for me now.’ The developing individual “learns to make this distinction through encountering others who apply it [the answer based on the value derived from a given community or social matrix] to him or her, before he or she is able to apply it to her or himself.”¹⁵ Thus even when the individual believes that he or she is making an entirely independent or autonomous decision, the response has been habituated through earlier stages of development unknowingly. To flourish, then, requires the transition from responding to infantile desires and the explicit directions of others to being the independent reasoner who can step back from both sets of influences without dismissing their importance, and more fully come to understand what it means for the individual to move toward the good life. Given the history of the influential social relationships in one’s life, flourishing can be viewed as always having been achieved in the context of the community given the history of the influential social relationships in one’s life, and this is further realized by the autonomous rational agent who comes to learn how to better cooperate with others (peers and members of other generations) in working toward the satisfaction of a range of common goods.¹⁶ It is on this last point of working symbiotically with others in pursuit of common goods that the independent moral reasoner may come to more clearly understand and appreciate the importance of the virtues of acknowledged dependence.

Having acquired and internalized ideas about flourishing as a result of the social

action really are sufficiently good reasons, *and* the ability to imagine realistically alternative possible futures, so as to be able to make rational choices between them, *and* the ability to stand back from our desires, so as to be able to enquire rationally what the pursuit of our good here and now requires and how our desires must be directed, and if necessary, reeducated, if we are to attain it.”

¹⁵ MacIntyre, *Dependent Rational Animals*, 70.

¹⁶ MacIntyre, *Dependent Rational Animals*, 74. This is not to say that flourishing always requires being utterly dependent.

knowledge taught by others, the individual is then reminded, by continued practice of the virtues, how dependent he or she once was and still is. MacIntyre suggests that commonplace virtues such as honesty, justice, courage, generosity, and temperance are necessary in the pursuit of the good life. But it is not necessarily because those particular virtues are beneficial to the individual *qua* individual so much as those virtues cannot even be understood outside of a community; hence they are integral to the common pursuit of the good for the community. The individual depends on the other in order to live the good life, as an individual's practicing of virtue and subsequent achievement of flourishing "is always open to being destroyed by what the other does."¹⁷ Though our periods of dependency fluctuate over the course of our lives, "the care that we ourselves need from others and the care that they need from us require a commitment and a regard that is not conditional upon the contingencies"¹⁸ that contribute to our dependency; instead, what is needed is an individual and communal recognition of the bonds of dependency that forge the foundation for flourishing as a community of individuals.

MacIntyre's approach emphasizes terms such as 'independent moral reasoner' and 'virtues of acknowledged dependence,' but what they might mean for the Third Age is difficult to determine without a better understanding of how to balance autonomy and dependence. Building on what had been done in feminist and care ethics before him,¹⁹ MacIntyre invokes a model of relational autonomy or relational agency. From a feminist theological perspective, Margaret Farley address autonomy and relationality as two obligating features of personhood.

¹⁷ MacIntyre, *Dependent Rational Animals*, 128.

¹⁸ MacIntyre, *Dependent Rational Animals*, 128.

¹⁹ See fn. 4.

The autonomy of individuals, their “capacity for self-determination as embodied, inspired beings,”²⁰ demands respect,²¹ because persons are ends unto themselves. Farley explains the condition of being dependent as a state of “fundamental relatedness to others.”²² Surviving and thriving in and because of one’s relation to others is acknowledged by MacIntyre, too, but Farley makes an important distinction that is insightful for an ethics of aging:

the capacity for relation is a capacity to reach beyond ourselves to other beings... We are who we are not only because we can to some degree determine ourselves to be so by our freedom but because we are transcendent of ourselves through our capacities to know and love.²³

Our relations with others push us to become someone different than we might have been, and we have the capacity to reciprocate – that is what Farley means by our being able to transcend ourselves. This relational dependence we experience helps us grow as individuals; it is not a deficit or to be associated with decline. Instead of undermining autonomy, relational dependency cooperates with one’s agency. The aging person has always and continues to pursue the good life in the midst of the other. There were, are, and will be times when the aging person’s dependence changes such that his or her pursuit of the good life may be partially thwarted, but those moments are occasions for one’s relational autonomy to be expressed in a new, and at the same time a familiar way – namely in relation and with the help of the other. The Third Ager is and can still be as independent as she or he has *always* been, but that the fear of diminished independence can be mitigated through an understanding of relational autonomy and the recognition of one’s fundamental dependency and sociality.

²⁰ Farley, Margaret. *Just Love: A framework for Christian sexual ethics*. (New York: Continuum, 2006), 212.

²¹ The same type of compassionate respect described in Chapter Three, fn. 104.

²² Farley, *Just Love*, 213.

²³ Farley, *Just Love*, 213.

With the addition of Farley's lens, MacIntyre secures the dialectic between dependency and agency as part of the human condition, and explains why the virtues that one learns and practices that enable one to flourish in community with others. In nuancing the relationship between dependency and agency, MacIntyre brings to the fore how it is that the individual can understand him or herself within a society that associates independence with the highest good. After reflecting on and practicing a number of learned virtues, the independent moral reasoner is better positioned to achieve the good life. However, as helpful as the virtues are in showing the individual how she or he can live well, they still do not paint a clear enough picture of the good life. Though the virtues outlined by Vacek, for example, help address how the aging person might live well in the Third Age, it remains to be seen whether particular goods are more conducive to the good life than others.

Martha Nussbaum And The Capabilities Approach

Martha Nussbaum's Capabilities Approach presupposes the dependence and sociality of persons and moves toward describing the particulars of flourishing. Before presenting the list of central capabilities, it is necessary to say a word about the nature of a capability. In the abstract, capabilities answer the question 'what is a person able to do and be?' They address whether or not an individual is enable or disenabled from an Aristotelian notion of flourishing or eudaimonia; they are not an assessment of whether or not an individual exercises a given opportunity. One's ability to flourish is made possible by an individual's natural abilities, education and upbringing, and the sociopolitical economic and ecological environment in which one lives.²⁴ Nussbaum proposes a list of central freedoms that are minimally required in order for

²⁴ Nussbaum, *Creating Capabilities*, 20-21. The types of capabilities defined within the text are basic, internal, and combined. Basic capabilities are the innate faculties or abilities with which one is born. Internal capabilities are

one to be able to flourish, thereby emphasizing the modern value of autonomy and individuality. For the aging person, the list is an attempt at answering the question ‘what makes flourishing possible during an experience associated with decline.’

Born out of the liberal tradition and in direct response to late 20th century political philosophies, the Aristotelian Capabilities Approach identifies minimally required freedoms of opportunity, or capabilities, that describe a vision of the good life under the conditions of pluralistic modern societies. This normative vision is not simply a thick description of the good life; the central freedoms are to be protected under law within democratic societies. Nussbaum disputes that the capabilities are to be interpreted as rights, but if they are in fact a necessary minimum requirement making the good life possible, the implicit claim is that they are fundamental entitlements. As a normative anthropology, the list of central capabilities is ethical from the start.

The Capabilities Approach And The Aging

Reforming the theoretical structures that currently inform socially accepted conceptions of the good life is admittedly a task that concerns the ideal scenario more than it does the real. However, in Nussbaum’s opinion, the ideals toward which we aspire are real in that they “direct our striving, our plans” supply “the basis for legal action,” and “acknowledge human life as it is” by expressing “a sense of how real people are.”²⁵ Her approach identifies certain shortcomings in society, and reminds persons of those goods to which they are entitled, and can evolve to meet

learned and developed traits that are also functions of the social and political environment in which one lives. Combined capabilities are considered to be the substantial freedoms that represent the “freedoms or opportunities created by a combination of personal abilities and the political, social, and economic environment.” A combined capability is the totality of the opportunity one has to exercise his or her freedom.

²⁵ Nussbaum, Martha. *Political Emotions: Why Love Matters for Justice*. (Cambridge, MA: Belknap Press: Harvard University Press. 2013), 383.

new basic goods derived from the experiences of persons in society. The Capabilities Approach is described as being ethical from the start in that it outlines what is necessary for the good or flourishing of the individual, asking “among the many things that human beings might develop the capacity to do, which ones are really valuable ones, which are the ones that a minimally just society will endeavor to nurture and support.”²⁶ What then does the Capabilities Approach offer for the good life, and how are those capabilities relevant to aging persons in particular?

Capabilities fit well within liberal societies that value autonomy insofar as individuals are afforded the opportunities to both make choices and develop and actualize a life plan. These freedoms to select, “so central that their removal makes a life not worthy of dignity,”²⁷ are intended to both identify a threshold²⁸ for the conditions and characteristics of dignity and to serve as a list-to-be-augmented as new questions of social justice arise. According to Nussbaum, a society that does not provide for the minimum level of capabilities does not qualify as a just society and effectually stymies the possibility of its citizens achieving the good life.²⁹ What basic entitlements, freedoms to select, or areas of individual and social good are deemed central then? The ten central capabilities are: Life; Bodily Health; Bodily Integrity; Senses, Imagination, and Thought; Emotions; Practical Reason; Affiliation; Other Species; Play; and Controls Over One’s

²⁶ Nussbaum, *Creating Capabilities*, 28.

²⁷ Nussbaum, *Creating Capabilities*, 31.

²⁸ Establishing a threshold list of capabilities distinguished Nussbaum from Amartya Sen who also first developed the capabilities approach. For Sen, however, the capabilities, understood as opportunities to select, are not to be viewed as abstract principles. Instead, the capabilities are to be regarded as quality of life measures akin to the UN Development Index. In this way, the capabilities are to be used as real political and economic metrics that identify the successes or failures of social policies vis-à-vis the capabilities that have been identified as central to the good life. This point will be brought to light in the following chapter.

²⁹ Nussbaum, *Frontiers of Justice*, 75.

Environment.³⁰ The value or importance of each may vary across the diversity of demographics within the aging population, therefore, attention will only be paid to those that can help reframe a vision of aging well.

If in fact MacIntyre's vision of the dialectic acknowledgement of dependence and independence is a primary social good capable of reorienting our sociocultural and political gaze while also attending to the actual needs of the aging, then certain capabilities must be prioritized over others. Life, bodily health, and affiliation are such basic capabilities. When they are secured at a minimum level, they facilitate the good life for the aging. "Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living,"³¹ reads Nussbaum's explanation of the capability of life. Seemingly self-explanatory, the aging may find difficulty in understanding this capability because of the ways that medical and cultural forces work to constantly redefine the 'normal' length of a human life, and what characteristics or state of being vis-à-vis health signal that life is no longer worth living. Regardless of the technological imperative, it is necessary that work be done to establish parameters for the natural lifespan which most persons should be able to achieve. Over-extending life or over-treating for the purpose of prolonging life is a threat because it creates the illusion that living to 120 years of age is a realistic possibility; however, that is not the case because a majority of aging Americans do not and will not have access to the technology that make such a radical extension of life possible. It is also a threat because, as was addressed in Chapter One, it perpetuates the cultural denial of mortality that precipitates a disproportionate amount of spending on life-prolonging and life-extending technologies when compared to the

³⁰ Nussbaum, *Creating Capabilities*, 33-34.

³¹ Nussbaum, *Creating Capabilities*, 33.

other health care needs of a vast majority of the population. This is not to say that aging persons or health care professionals should resort to medico-moral pessimism; instead, aging persons should not feel pressured to extend life for the sake of extending life. As a threshold, neither does the capability of life mean prolonging life, nor does it mean an avoidably truncated life.

Similarly, bodily health speaks to the aging regarding access to health care while drawing attention to potentially overlooked contributors to health: nourishment and housing. Good health is something that already and will continue to vary from person to person, and given the aging population's diversity in both age range and developmental progress it will be important to test and assess the current standards of health³² in an effort to establish parameters that more closely resemble the 'normal healthy' aging person. Various medical associations have offered a vision for good health as outlined in Chapter One, but actively ensuring adequate nourishment and shelter are not germane to the medical profession, lest it is redefined as social medicine, despite their role in contributing to one's optimal functional health. Therefore, raising awareness and assuring the delivery of such services requires social solutions, because "in the absence of suitable support and care they [the aging] will not be able to live lives worthy of human dignity."³³

Moreover, the issues associated with living arrangements for aging persons extend beyond inherent problems of institutionalization and home care (i.e. elder abuse and neglect). The ability to make mortgage or rent payments when one is no longer working, or financial insecurity (perhaps as a result of a health care emergency) threatens the ability to live in homes that are conducive to one's flourishing demonstrates the importance of considering adequate

³² See Chapter One, pp 38-45.

³³ Nussbaum, *Political Emotions*, 120.

housing as a capability for the aging. For Third Agers of lower socioeconomic statuses this problem is further complicated. Particularly persons of color whose history of earning may have been unfairly influenced because of their race or ethnicity may be unable to afford the type of living arrangement that meet their vision of the good life. Similarly, the aging process, as has been noted in Chapter Two, affects men and women differently, primarily when it comes to lifetime earnings and life span. For women who must support themselves during the aging process, the opportunities to live well can be stymied by the same series of socially constructed injustices that made the workplace and departure from the workplace unfair. Identifying the type of housing commonly envisioned as part of the good life will require research from the Housing and Urban Development Department, and likely from smaller organizations that are more closely in touch with the lives of all socioeconomic strata within the aging population whose findings can better represent an average or adequate kind of housing.³⁴ Once the adequate level of housing is identified, the question of financing or subsidizing the housing will require further consideration through the retooling or various social and economic policies. If housing communities that approximate an aging person's vision of independent living can also create the space for communal engagement, aging persons may not be as reluctant to move into such a community. Independent-enough living and opportunity for social interaction are sound reasons to pursue such a project, but an exceptionally important reason to consider how to correct the cultural aversion to living in a community later in life is that of the association of such communities with medicalized assisted-living facilities. As Chapter One has made clear, not all aging people will experience health problems that require full or even part-time care, but living

³⁴ This strategy will be explored further in the next chapter through the principle of subsidiarity found within Catholic Social Teaching.

independently carries the potential for a health need going unaddressed. That risk could be mitigated if there were an unobtrusive system of checking-in within a housing community. At the intersection of these socio-economic and health issues is the field of public health, which is capable of responding to some of these issues. Making health more accessible, either through expanded transportation services, the construction of more local health care centers, and/or providing lower cost care (made possible by various subsidies or philanthropic funding), can work to alleviate some of the health and health-related financial problems a majority of Americans may face. Similarly, public health programs can assist in ensuring that aging persons who are forced to live in communities not of their choosing or liking are not being forced to further sacrifice opportunities for healthy living – the healthy living that is prescribed by the medical field. Those opportunities may include increasing access to affordable quality food stores, and also access to relevant features of healthy living, such as exercise. An additional benefit of public health’s intervention in realizing some of what is outlined by Nussbaum and the type of dependent care of which MacIntyre speaks, is that it fosters the belief that the life and health of the aging person are not only limited to the delivery of health care services; one’s health is also influenced by one’s opportunities to be involved in the community. In keeping with the notion that the Capabilities Approach is intended to be understood and applied cooperatively, it becomes clear that the opportunity for the aging person to have affiliations with others is necessary for the fulfillment of the good life.

Nussbaum describes affiliation as architectonic in the Capabilities Approach given the ways in which it supports, informs, and is present in all of the other capabilities. A lacking or deficient affiliation undermines one of Nussbaum’s foundational claims about human sociality, a

claim that resonates with MacIntyre. Not only is living in community part of the human experience, but flourishing is inextricably linked to our interdependence. As pointed out by Farley, the good life we come to possess is only possible through and enhanced by our relationships with the others. To be denied the ability to associate with others or the opportunity to live in relation(ship) with one's community not only impedes human flourishing but also undermines what it means to be human. As a capability, a minimum threshold of affiliation ensures that individuals are able to fulfill the natural need for relationships, learn, re-learn and continue to practice the virtues of MacIntyre and/or Vacek, the importance of which cannot be understated. Having come to face once again with what it means to be dependent in some form, the aging demonstrate a need for opportunities to affiliate.

Nussbaum separates affiliation into two distinct meanings, the first of which reads: "Being able to live with and toward others, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another."³⁵ Given the emphasis placed on individualism, an aging person's being entitled to and proactively supported in the facilitation of his or her interpersonal relationships can help to mitigate some of the socially and culturally imposed problems of isolation (i.e. self-identity, self-worth) as one ages. If part of being able to age well is continuing to psychosocially develop and embrace new modes of self-expression, then basic support structures ought to provide the environment in which one can satisfy a fundamental human need, a claim supported by Nussbaum in other iterations of the capabilities: "protecting this capability means protecting

³⁵ Nussbaum, *Creating Capabilities*, 34.

institutions that constitute and nourish such forms of affiliation.”³⁶ As the Sant’Egidio model demonstrates, the idea of a communal focus on intergenerational fellowship (and active care) can provide the type of affiliation needed to support the flourishing of aging persons. However, the social interaction afforded by affiliation cannot be limited to the praiseworthy Sant’Egidio community or other such models because of its reliance on the goodwill of volunteers. A threshold level of this capability requires a social and political commitment to offering inclusive and meaningful opportunities for social engagement that not only work to satisfy the social interaction needs of the aging but that are also structured to better facilitate intergenerational interactions. The purpose of intergenerational inclusivity is to combat the social and cultural narratives that portray the Third Age as a phase of decline, loneliness, and sometimes meaninglessness outside of family life. Structures encouraging affiliation can also provide places in which aging persons can reflect and reminisce while also forging fruitful relationships with those whom the aging persons might not necessarily encounter in day-to-day life. But, these opportunities must remain opportunities and not obligations to interact or worse, serve younger generation lest they risk connecting the good life in aging to social productivity once again. A concerted political commitment to the aging in this way will publicly honor Nussbaum’s second element of affiliation: “having the social bases of self-respect and nonhumiliation; being able to be treated as a dignified being whose worth is equal to that of others,” which entails “provisions of nondiscrimination.”³⁷ For aging persons subjected to ageist practices in the workplace or elsewhere, a more public denouncement might help to curb the problems of forced retirement or euphemistically being ‘over qualified’ for jobs later in life. Advocating for the fair and equal

³⁶ Nussbaum, *Frontiers of Justice*, 77.

³⁷ Nussbaum, *Creating Capabilities*, 35.

treatment of aging persons in various social settings helps debunk myths about aging as much as it works to actively facilitate the good life for Third Agers.

In addition to the public support made possible through affiliation, aging persons, like all other members of society, require an opportunity to exercise practical reason as part of a minimum vision of the good life. Autonomy has been implicit in the aforementioned capabilities insofar as each are understood as being important in bringing to life an individual's vision of the good life. That vision of the good life presumes an individual's autonomy. "Being able to form a conception of the good, and to engage in critical reflection about the planning of one's life,"³⁸ another way of describing autonomy or one's capacity for autonomy, is already central to the cultural and political ethos of Western liberal societies. Emphasizing the freedom to choose and to determine one's life is not presented uniquely in the list of capabilities, but for aging persons whose understanding of autonomy has been shaped by the cultural influences addressed in Chapter Two, reconsidering practical reason as a capability is worthwhile. The role of autonomy within biomedical ethics was examined through the work of Beauchamp and Childress who identify autonomy as one of four *prima facie* duties to be satisfied in the delivery of health care. Respect for an individual's ability to choose and to determine a life plan is not an entirely passive (or negative) obligation; "it includes, in some contexts, building up or maintaining others' capacities for autonomous choice while helping to allay fears and other conditions that destroy and disrupt autonomous action."³⁹ Put differently, this means actively working to enable others to act autonomously. The act of supporting or enabling the autonomy of others is precisely

³⁸ Nussbaum, *Creating Capabilities*, 34.

³⁹ Beauchamp, Tom L. and James F. Childress. *Principles of Biomedical Ethics. Sixth Edition.* (New York: Oxford University Press. 2009), 99.

what MacIntyre aimed for in his discussion of relational autonomy; one can still be autonomous and one can still be free with the help of others. What disrupts or interferes with autonomy is not specified, but Beauchamp and Childress highlight the gatekeeping function of competence regarding autonomy in regards to coercion or exploitation. Being subjected to the images discussed in Chapter Two suggests that aging persons are enticed or shamed or worse, exploited when it comes the social imageries of how they should view themselves and the lives they should try to achieve. This raises the question of whether or not aging persons are violated in their dignity, given the real and social constructed dimensions of their vulnerability. Their vulnerability is contrived insofar as the social construction of aging and ageism informs the opinion and treatment of aging persons and it is real regarding the struggles of self-identity once one's economic and social roles change in retirement. The analyses drawn to our attention in Chapter Two have revealed that at the very least aging persons are *susceptible* to exploitation resulting from compelling and seemingly unavoidable social norms. In promoting and guaranteeing the capability of practical reason it is incumbent upon society to more carefully and selectively speak of, market products to, and care for the health and socioeconomic needs of aging persons to avoid limiting their autonomy as it relates to the question of competence. This would resemble the ways in which advertising campaigns for morally questionable or health-damaging products must not be targeted toward minors. Furthermore, advocating for aging persons creating their own vision of the good life and creating a life plan to achieve such a vision will require a public rebuking of the ways in which an individualist-leaning independence is promoted and dependence disparaged as undignified. This much larger task resonates with Nussbaum's claim that the very theoretical structures upon which notions of the good life are

built need to be reshaped. Reconsidering dependence and independence in light of sociality, and embracing the fact that all “citizens live in relationships of asymmetrical dependency for large portions of their lives”⁴⁰ whether that be during childhood, bouts with illness or during the Third Age, is the first step in changing how care for Third Agers is conceptualized and provided. When one recognizes the value of interdependence over independence and guarantees the practical reason of aging persons, how the aging choose to exercise their freedoms requires a broad range of accessible opportunities for such expression. The capability that speaks to the importance of varied modes of self-expression is play.

Simply stated, play means, “being able to laugh, to play, and to enjoy recreational activities.”⁴¹ Beyond the intuitive value of play, it is able to contribute to the good life for the aging person in two related ways. Practically speaking, engaging in leisure activities can provide both mental and physical health benefits. For those partaking in activities such as walking, bike riding, or recreational sports, there are the health benefits of managing one’s weight, improving or maintaining cardiovascular health, lowering cholesterol and reducing the risk of hypertension, limiting the chances of osteoporosis, and avoiding other pathologies associated with a sedentary lifestyle. There are similar mental health benefits as well given the ways in which exercise causes a neurochemical reaction in which endorphins are released, placing the individual in a more contented state. Anecdotally, individuals who exercise frequently might say that such activities are effective modes of releasing stress, or helpful ways to balance mental health in light of those detrimental factors one may experience. According to the professional guilds referenced

⁴⁰ Nussbaum, *Political Emotions*, 121.

⁴¹ Nussbaum, *Creating Capabilities*, 34.

in Chapter One, such exercise is important in achieving the healthy life, which those guilds equate with the good life. However, the anecdotal remarks about feeling better after engaging in recreational activities or exercising points to the second way in which play is an integral capability for aging persons especially. Quality of life is a phrase often invoked in health care when it comes to evaluating whether or not to proceed with a suggested or possible course of treatment, defined by the WHO as

Individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affecting a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationship to salient features of their environment.⁴²

In the event that a patient is not able to live the type of life that he or she has planned, including but not limited to essential and recreational daily tasks identified with the good life, then the suggested treatment may be deemed too burdensome in light of the overall health or wellbeing of the individual. For aging persons, having the opportunity to engage in and receive the necessary social and political support to take part in activities essential to their quality of life is of the utmost importance. Opportunities for play then are necessary insofar as they help meet the physical and mental health understanding of the good life, aid in the actualization of one's autonomously chosen life plan, and, in the case of the aging, offer outlets for revitalized or new modes of self-expression. Generally, play affords the individual an opportunity to step out of real life into a temporary world "with a disposition all of its own."⁴³ Play presents benefits beyond

⁴² "WHOQOL: Measuring the Quality of Life (1997)" Division of Mental Health and Prevention and Substance Abuse, World Health Organization. Accessed September 5, 2016, http://www.who.int/mental_health/media/68.pdf.

⁴³ Huizinga, Johan. *Homo Ludens: A Study of the play-element in culture*. International Library of Sociology and Social Reconstruction. (London: Routledge, 1949), 8.

those of physical health and mental health, such as those outlined by Johan Huizinga.⁴⁴ For the aging person, the capability of play is indispensable – it reminds the individual that regardless of what assumptions might be made about him or her, aging does not inhibit the fulfillment of the good life.

Dependence, Disability, and Aging

The Capabilities Approach, rooted in an Aristotelian ethics and political philosophy, is Nussbaum's way to critique John Rawls' (and those who have come before him) contract theory. Her analysis is critical both in terms of addressing the shortcomings in the approach employed by Rawls and constructive in her theoretical additions leading to more just practical outcomes. She identifies three core unresolved issues, the first of which is the combined issue of "impairment and disability."⁴⁵ The problems of modern contract theory, rooted in the 17th century, start with the subjects of the social contract: women, children, or persons with disabilities neither authoring or contributing to early contractarian political philosophy; their interests never factored prominently in such proposals. Though Nussbaum admits that several of the missteps were moderately corrected concerning women and children, she maintains that contractarian social doctrines excluded persons with disabilities despite the fact that they are equally citizens who should be entitled to fair treatment.⁴⁶ While this is certainly correct, Nussbaum's project does not adequately attend to the structures and relations that form the social landscape resulting in the dis-enablement based on the threshold she establishes, or the quality of

⁴⁴ Rituals, as a form of play, can stimulate the imagination and enable an individual to transcend his or her present current state of being; organized sport, because of its competitive element, forges bonds among teammates within and outside of the competition's context while also providing all participants the possibility of winning, which comes with its own psychological benefits.

⁴⁵ Nussbaum, *Frontiers of Justice*, 14.

⁴⁶ Nussbaum, *Frontiers of Justice*, 14.

having one's capabilities denied, of aging persons by focusing on specific impairments such as mental disabilities instead of other pertinent factors that foster or thwart one's capabilities.

Nussbaum's very notion of disability must be corrected in light of her capabilities framework. In earlier writings, her understanding of disability is limited to functional disability, a problem repeated by omission in her explication of the central capabilities. A functional understanding of disability comes out of a medical model that emphasizes a physical or cognitive impairment that limits an individual's ability to participate in daily life. Sara Goering, a philosopher and bioethicist, notes that the functional or medical understanding of disability has been reported to make disabled persons feel "excluded, undervalued, [and] pressured to fit a questionable norm."⁴⁷ Regarding disabilities and the capabilities approach, Nussbaum turns to care as the primary response to an individual's impairment, rather than a constructive explication within the list of central capabilities itself. Though aware of the ways in which such disabilities affect one's place in society, she does not acknowledge the importance of the social model of disability despite its obvious relationship to the Capabilities Approach.⁴⁸ The social model brings light to the fact that many persons with disabilities report the primary experience that defines their disadvantages to come from their "unwelcome reception in the world in terms of how

⁴⁷ Goering, Sara. 2015. "Rethinking disability: The social model of disability and chronic disease." *Current Reviews in Musculoskeletal Medicine* 8 (2), 134.

⁴⁸ Eva Feder Kittay Writing on disability, dependency, and ethics of care before during and after Nussbaum published *Frontiers of Justice and Creating Capabilities*, Eva Feder Kittay represents the modern voice on the relationship between questions of disability and justice. In a 2015 article, she criticizes Nussbaum for giving an ethics of care "short shrift" in *Frontiers of Justice*, but argues that the capabilities approach, because of its openness, is amenable to an ethic of care, and can in fact strengthen such an ethic. The role of an ethics of care will be considered further later. Kittay, Eva Feder. "A theory of justice as fair terms of social life given our inevitable dependency and our inextricable interdependency," in *Care Ethics and Political Theory*, ed. Daniel Engster and Maurice Hamington. (Oxford: Oxford University Press, 2015). Other notable works include: *Love's Labor: Essays on Women, Equality, and Dependency* (2013), "At the Margins of Moral Personhood (2005)," "Dependency, Equality, and Welfare (1998)," and "When Caring is Just and Justice is Caring: Justice and Mental Retardation (2001)."

physical structures, institutional norms, and social attitudes exclude/denigrate them”⁴⁹ rather than their physical limitations. Some of those attitudes may be characterized as stigmatization, marginalization, and outright discriminatory practices. This second understanding of disability acknowledges physical and cognitive limitations as well as their impact on one’s participation in society, but nuances the distinction between disability and impairment, where the former is a physical condition and the latter a function of external forces. In other words, the social model of disability argues that the impairment(s) is primarily problematic because of society’s failure to recognize and respond to the needs of such persons, so problematic that society’s failure to address its role in marginalizing disabled persons has been characterized as “oppressive.”⁵⁰ If the Capabilities Approach serves to name certain characteristics of the good life and a threshold level of capability, then Nussbaum must speak to how disability can be viewed as a dis-enablement or a social construction that is antithetical to capabilities. Changing the language from disability to dis-enablement is more in line with Capabilities Approach and does not reduce disabled persons to their impairments. Moving to dis-enablement can expand our understanding of the implications and realities of being both functionally and socially disabled and force a reevaluation of the combined capabilities afforded to such persons. Dis-enablement allows an ethics of aging to engage in both the functional and social impairments of aging persons whose experiences have been known to embody both forms of disability without suggesting that aging persons are inherently disabled (functionally) or subjected to the same types of socially constructed barriers to living the good life. A fluctuating experience of dis-enablement is capable

⁴⁹ Goering, “Rethinking disability,” 134.

⁵⁰ Crow, Liz. “Including all our lives: renewing the social model of disability” in *Encounters with Strangers: Feminism and disability* ed. Jenny Morris. (London: Women’s Press, 1996) 207.

of speaking to individuals who do not or may not ever experience the type of physical and cognitive decline that may be like a disability. Interpreting Nussbaum's disabilities as dis-ablements can then be considered in light of MacIntyre's continuum of dependence insofar as we are subjected to times of more or less dis-enablement.

MacIntyre has a much more targeted critique than Nussbaum on the question of social disability. His argument is in part borrowed from Foucault in that he looks to the very structures of power themselves as being inherently discriminatory. "The institutionalized giving and receiving" with a society that may be said to be fair and just, "are always structures of unequal distributions of power, structures well-designed both to mask and to protect" those in charge.⁵¹ Within the context of social disability, it can be seen how aging persons are dis-enabled by the very power structures erected to support their needs as well as those of others. For MacIntyre the physical and cognitive plight of some aging individuals cannot be overlooked insofar as those experiences remind us of dependence and necessitate a response of care from others; however, the way in which those dis-enabling moments are connected to social structures is a more pressing issue. Dis-enablement that results from socio-political structures can and should be avoided, and is in part a result of the continued failure of liberal societies to acknowledge dependence. Without awareness of the ways in which the social consciousness is communicated through power structures that do not recognize the ways in which aging persons are thought of and treated, no model of care raised by MacIntyre, Vacek, or Moses, nor the conception of human dignity outlined by Nussbaum will ever come to fruition. Failing to be mindful of and actively show concern for the dis-enabled is an example of and will perpetuate "far from

⁵¹ MacIntyre, *Dependent Rational Animals*, 102.

inevitable”⁵² unequal and unfair treatment. A remark such as that points to both the blind spot(s) possessed by those determining the principles of justice for a given society and how certain individuals or groups can be unknowingly subjected to systemic neglect resulting in the construction of a social or cultural opinion that continues to devalue rather than raise up such targeted groups.

While the term ‘neglected’ mischaracterizes the treatment of the aging population vis-à-vis marginalized groups who have not featured prominently in policymaking or who have actually been mistreated in labor health care or other social situations, the aging have been the subject of a cultural narrative that does suggest an inherent indignity to the aging process. As a result, aging persons are subjected to being dis-enabled from fulfilling the good life. A primary contributor to the ‘aging as bad’ narrative is the pathologization of aging. As a result of medical ethicists’ and medical professionals’ linking aging to disease or abnormality, a negative opinion about aging persons themselves is cultivated within society. Somehow aging persons are speciously linked to being less than the other because of a perceived-to-be inevitable physical and mental decline that is believed to render individuals useless. However, MacIntyre highlights the reality of the dependence that all persons have experienced and will likely experience, and maintains that the good life is still possible. Moving beyond the simplistic arguments that aging is a disease and reaffirming the realities of dependency can help break down the medical stigmas of the aging process and promote the other ways in which care can be provided.

In addition to the issue of pathologization of aging, Third Agers are perceived to be less than their younger counterparts when it comes to their contributions to society. Nussbaum argues that the typical social contract by which modern liberal society abides falls short in

⁵² Nussbaum, *Frontiers of Justice*, 15.

distinguishing between the “‘normal’ variations among ‘normally productive’ citizens”⁵³ that lead to the aging, who may be traditionally (read: economically) less productive, being classified as impaired to some degree. However, it has been shown that the aging’s “relative lack of productivity under current conditions is not ‘natural,’”⁵⁴ but rather is the result of socio-cultural practices that discriminate against aging persons, i.e. ageism. Perpetuating a belief that links increasing age with commensurately decreasing productivity and being labeled as impaired can lead to both internal (self-identity) and external (distancing by others) psychosocial problems that can unfairly burden aging persons. Normalizing the ‘aging is inherently debilitating and undignified’ view unfairly informs the idea of the good life in aging in such a way that fair and equal treatment moves farther from reality. This very process of removing the individual from the workforce is an instance of dis-enabling, a social constructed obstacle to living the good life.

One of the ways in which aging is perceived to be undignified is through the assumption that complete independence is necessary for living a dignified life. As has been outlined in Chapter Two, the cultural import of autonomy as a defining characteristic of the good life can thwart mutually beneficial intra- and intergenerational relationships, family relationships, and prove to be detrimental to the care needed by the aging person. Critical of such a view, Nussbaum argues that presupposing independence as the hallmark of dignity is mistaken because it overlooks those who may spend periods of their lives being somewhat dependent upon others, for example children who are not characterized as lacking dignity because of their vulnerable state. Echoing the argument of MacIntyre, she claims that “nobody is ever self-sufficient” because “the independence we enjoy is always both temporary and partial,” and it is necessary

⁵³ Nussbaum, *Frontiers of Justice*, 105.

⁵⁴ Nussbaum, *Frontiers of Justice*, 113.

that our culture move toward accepting the need for “care in times of dependency.”⁵⁵ Aging persons who require the help of others do not cede their value as individuals because of a loss, temporary or permanent, of independence. The good life in aging therefore cannot be defined by or limited to independence. Adjusting the focus from individualism to individuality promotes the value of the person, or in this case the value of the aging person, without placing conditions on his or her self-worth or social value. Turning toward individuality creates a space in which autonomy, understood as both the freedom to choose and the freedom of self-determination, can be preserved without dependence being perceived as an impediment to the good life. As has been shown through the use of relational autonomy, dependence can instead be viewed in a rather positive light, perhaps as helpful in one’s autonomous pursuit of the good life. Such a cultural shift requires an openness to CA, but the independence-dependence dynamic in American culture is only one way in which aging persons are subjected to unfair treatment.

Taken together, these issues point to the ways in which aging persons are dis-enabled from realizing the good life, and being denied fair and equitable treatment. Aging persons are sometimes treated in ways like those who are physically or mentally impaired. They are sometimes stigmatized as being ill or prone to sickness or injury, and are not of central importance when considering social visions of the good life. Improving or maintaining their functional health (physical and cognitive) is but one way of starting to enable aging persons, but this task is not made clear by Nussbaum. She leaves out aging persons who fall under the category of socially disabled, and leaves it to them to seek the kind of holistic care for the sick and functionally disabled spelled out in the list of central capabilities. Nussbaum argues that “health care, political rights and liberties, and equal citizenship” are requisite qualities for the

⁵⁵ Nussbaum, *Frontiers of Justice*, 218-219.

good life, and that when it comes to providing equitable opportunity for satisfying the good life across all social demographics, emphasis needs to be placed on “care as a primary social good.”⁵⁶ However, Nussbaum’s own shortsightedness on the question of aging persons in the face of social disability makes drawing the guidelines for the satisfaction of a capability of health and actualization of care as a primary good difficult. Incorporating the language of social disability into an ethics of aging would bring about a revised vision of care that goes beyond the physical and mental health needs of aging persons. In addition to responding to the needs of aging persons who may or may not experience deficits in health, care can be directed toward to the condition of being marginalized by society in a way analogous to the model of Sant’Egidio. Being entitled to care can also help to mitigate the tension of independence-dependence in the aging population and in society’s perception of that struggle, but the current social programs do not provide an adequate level of care to facilitate aging well. Organizing care into a primary social good will require that the very capabilities themselves be reconsidered in light of social disability and dependence in order for aging persons to truly be enabled to age well.

Conclusion

As Nussbaum notes, valuing the dignity of all individuals will require a reforming of the public consciousness regarding what values are necessary for living the good life. However, such a momentous task is not possible if a list of conditions indicative of a dignified life is all that is offered. Helpful as the capabilities are, their efficacy is difficult to infer given their disputed status as either descriptions of the good life or normative claims about the good life. At the very least they are helpful in their attempt as political protections or conditions of a just society to provide an individual an opportunity to live the type of life that he or she wishes. The nature of

⁵⁶ Nussbaum, *Frontiers of Justice*, 12.

the capabilities is such that they encourage the individual to conceptualize what types of freedoms might be central to a good and dignified life. The political component of the Capabilities Approach can comfort the aging individual who worries about losing his or her freedom(s) just as it protects the aging individual who is in need of help from social institutions when it comes to actualizing his or her good life. The Capabilities Approach is amenable to a society that values autonomy, but its emphasis on freedoms or opportunities must be read within the context of Nussbaum's other works and with MacIntyre regarding dependency and relational autonomy. Without attention to the ways in which the individual has been shaped by the virtues of acknowledged dependence the cultural narratives about individualistic independence will persist and thwart an ethics of aging. The concept of relational autonomy works to preserve the individuality, the freedom, and the independence of the person while calling to mind the ways in which one has arrived at such a place with the help of others. For an ethics of aging it is necessary that this concept be lifted up because of its ability to cross the generational lines. Those on the younger side of the generational divisions perpetuate socially constructed visions of aging that exacerbate relationships of asymmetric dependency, which can be improved if younger persons would be more receptive of MacIntyre's and Farley's notion of relational autonomy. Similarly, the aging need to turn to the model of relational autonomy as a way of breaking them out of patterns of living that fulfill detrimental cultural norms (i.e. living independently because one believes he/she has to). Recognizing and working with one's dependence does not force the individual to compromise his or her autonomy, but instead asks the individual to accept that he or she has always needed help from without and that that fact has never stopped him or her from pursuing a self-identified range of goods. Highlighting the

experiences of dependency that all individuals have throughout their lives while also emphasizing the ways in which through those experiences individuals learn, apply, re-learn, and re-apply virtues instilled in them by the community allows persons to not sacrifice being individuals. In fact, the care that one may have received during times of dependency made possible the very autonomous pursuit of the good life – this reality does not categorically change in aging, only its perception by others and the aging person him or herself as informed by external forces. Negotiating dependence and autonomy is paramount in an ethics of aging; however, there is more to achieving the good life in aging than learning to embrace one’s relational agency.

Within an ethics of aging, protecting relational autonomy becomes part of the task of CA. Nussbaum addresses the fact that CA’s vision of dignity or the good life is not only theoretical; instead the Capabilities Approach is intended to have practical political implications. The freedoms identified in the Capabilities Approach are to be promoted and protected by a just society, not just idealized or strived for by individuals curious about achieving the good life. For Nussbaum, justice is achieved when all members of society are given equitable opportunities to live the dignified life that she envisions (informed by the experiences of others, of course). The justice component of the Capabilities Approach requires a more careful examination of the capabilities themselves in their three forms: basic, internal, and combined. Treating the list of capabilities only as freedoms or conditions of dignity and overlooking their secondary aim reduces them to mere abstractions. The political dimension of the Capabilities Approach accounts for the fact that not all relationships will be as harmonious as MacIntyre, Farley, Nussbaum, and others would hope. For the aging, the protections afforded by the Capabilities

Approach are integral to their visions of the good life, but also uncover practical questions of distributive, commutative, and social justice. For the aging person who reexamines the capabilities he or she possess in a new phase of life, assessing whether or not one has been treated fairly and enabled to live or dis-enabled from living a good life is important.

CHAPTER FIVE

CATHOLIC SOCIAL TEACHING AND AGING

Introduction

The previous chapters have shown that living the good life the Third Age is complicated by the normative visions of the good life communicated through the narratives of medicine, consumer culture, theology and theological ethics. Medical and cultural imageries of aging well present the good life as a static good to be achieved; the good life in aging can be had if one is functionally healthy, consumes certain goods, lives independently, or is a productive member of society. Viewing the good life in aging as a fixed achievement is contrasted with theological approaches that view the good life as a state of being, shaped by virtue and directed toward existential fulfilment not reducible to consumer goods. The theological vision of the good life in aging depicts the Third Ager as continuously striving to live well in relation to God and to others in the community. Chapters One and Two ultimately emphasized the individual's responsibility in aging well, which is motivated and reinforced by the cultural value placed on independence and individuality. Autonomy as individualistic independence was explored in Chapter Two, and while there is no disputing the status of individual freedom as a basic anthropological condition and its moral significance as an American cultural value, its interpretation has weakened an equally important anthropological feature, namely sociality. In order to address this defect of the first two chapters' findings, the third chapter appealed to theological responses with the hope of

offering a more holistic approach to aging well that recognizes the social dimension of human experience. However, the wished for socio-cultural corrective proved insufficient because the theological approaches are not especially attentive to the social-institutional dimensions of aging well beyond the idea of living well in community. The theological sources that speak directly to the good life in aging do not investigate the role of social institutions in directing, shaping, and informing the lives of Third Agers; however, in other contexts, theologians and ethicists are attuned to identifying the ways in which certain individuals respond to those very structures. Surely, any attempt at counterbalancing the type of American independent individualism witnessed in the first two chapters must be met with a more robust social response. Yet certain theological perspectives, despite their attempts to transcend medical and cultural imageries of aging well, unfortunately turn to productivity or contribution to society as part of what it means to live the good life in the Third Age. This reveals the primary problem with the sampling of responses to the question of aging well explored so far in the dissertation: while the type of individualism espoused by American culture contributes to several socio-cultural obstacles to living the good life in aging, existent proposals for aging well are similarly influenced by individualistic tendencies.

Although the theological responses surveyed in Chapter Three further support the claims made about individualistic responses to aging well, the overall vision of aging well cannot be overlooked. In particular, the virtues approach used within theological ethics is integral in establishing an ethics of aging. While mere training in virtue alone is not capable of overcoming the broader values and beliefs held within a larger pluralistic context, cultivating the right dispositions in individuals, Third Agers and other persons alike, so that they might respond to the

needs of aging persons in the appropriate manner is essential for the flourishing of all. The virtues approaches place responsibility on the individual to live well, but one's receptivity to virtues ethics presumes an understanding of autonomy and sociality, or dependency, that is different than the broader American culture as has been demonstrated in Chapter Two. Thus, living the good life imagined in a communitarian setting encounters difficulty in a pluralistic society, and requires a complementary approach in order to more firmly establish an ethics of aging. Quelling the American cultural fears of individual freedom being diminished by embracing sociality and dependency as features of personhood precipitated a turn to Nussbaum's Capabilities Approach. The Capabilities Approach addresses that American concern by framing the dignified life around specific freedoms one should be enabled to exercise; the good life in the Capabilities Approach is the dignified life of being minimally enabled to freely choose from a range of capabilities what is in accord with an individual's vision of flourishing. However, for Third Agers, a normative anthropology that supports autonomy alone is not sufficient. Despite the presumed democratic society of the Capabilities Approach, the good life remains the task of the individual alone – 'exercise the capability(ies) that suit you' – how the list is to be secured remains the important social ethical question. Appealing to both Nussbaum's capabilities and MacIntyre's communitarian-virtues approach began the type of dialogue needed to address part of the impediments to aging well posed by individualism. MacIntyre responded to the social experience of aging well on a small scale, but he underestimated the role of social institutions in achieving the good life in aging. What is needed for an ethics of aging in modern America is an approach that negotiates the fruits of both the Capabilities Approach and a MacIntyrean communitarian ethic. Engaging these dialectically will enable us to formulate a more adequate

response to the question of aging well as a social being in the face of independent individualism. This alone, however, is only the first step in creating a groundwork for an ethics of aging.

The second task is to complement the important but sometimes too individual-centric theological perspective with a framework that accounts for the aging person as social agent whose good life cannot be reduced to autonomy. The proposed framework for responding more comprehensively to the question of aging well is the tradition of Catholic Social Teaching (CST). Oftentimes the principles of CST are viewed only as guideposts for the good life in that they can identify a series of ideals to live by; however, the principles do much more because of their ability to inform and organize both individuals and the institutions through which lives are mediated. The principles of CST take up what both the Capabilities Approach and virtues lack, and when taken together, the three complementarily provide a framework for an ethics of aging that attends to the autonomy of the individual and his or her authentic development within the socio-cultural milieu of modern American life. CST can be described as a form of “communitarian liberalism” because it identifies the primacy of “the social nature of the human, human autonomy and its concomitant responsibility,”¹ and when it is reinterpreted for the aging, its principles will reveal an adequate foundation upon which an ethics of aging can be built. Establishing this groundwork will first require a further examination of dependency and the capabilities in view of CST with particular attention to the need for principles. Then I will offer a reinterpretation of the principles in light of the competing visions of and impediments to the good life in aging revealed in the first part of the dissertation.

¹ John A. Coleman, SJ. “The Future of Catholic Social Thought,” in *Modern Catholic Social Teaching: Commentaries and Interpretations*, ed. Kenneth R. Himes, O.F.M (Washington: Georgetown University Press, 2005), 527.

The Capabilities and Catholic Social Teaching

Throughout Nussbaum's articulation of the Capabilities Approach certain central assumptions are made. First, the Capabilities Approach relies upon two anthropological claims that both ground and direct the capabilities themselves: dignity and sociality. As the list of capabilities is explicated, the mutually reinforcing relationship between these two ideas becomes apparent – dignity requires that others recognize individuals as individuals worthy of recognition and without such social recognition, the individual does not live a fully dignified life. This is witnessed by capabilities such as bodily integrity and affiliation, practical reason and control over one's environment, life and the expression of emotion, all of which confirm a reciprocity that champions one's value as an individual and how that value is to be both respected and fostered impersonally. The freedoms identified by the Capabilities Approach are central to an individual's dignity, but that dignity is conferred by and lived out in relation to others. The Capabilities Approach "begins from a political conception of the human being"² that does not only mean being involved in social life. For Nussbaum, a political conception of the person affirms the relationship between individual's dignity and the function of the state as the protector of its citizen's dignity. How dignity functions in view of sociality and the role of the state must be explored further.

Articulating Nussbaum's definition of dignity is impossible to separate from the very capabilities themselves for they represent essential features of a dignified life. Though the capabilities are often critiqued within political philosophy because they are reached intuitively and inductively rather than reasoned deductively, the value of the capabilities comes precisely

² Nussbaum, Martha. 2006. *Frontiers of Justice: Disability, Nationality, Species Membership*. Tanner Lectures on Human Values (Cambridge, Mass.) Cambridge, Mass.: Belknap Press: Harvard University Press. 180.

from their ability to speak to practical needs identified from individual experience. They capture the vision of a life lived above the threshold levels of capabilities, while highlighting the ways in which those capabilities are socially mediated. The primary benefit of dignity being interpreted in an inductive way as it is in the Capabilities Approach is that it comes from the human person first, and then only later is formalized for the purposes of assessing the fairness of social institution or structures. She is careful to place emphasis “first and foremost on individual persons and only derivatively on groups”³ as the source of claims about a dignified life because the individual’s experience has already been shaped by larger social groups or institutions. In this way, the very dignity of the person is socially mediated, calling for an institutional response when an individual’s dignity is not fully protected and promoted. Nussbaum argues for a liberal democratic political system capable of responding to the needs of individuals, to protect the freedoms believed to be integral to a dignified life, but cautions that the political system alone is not capable of identifying instances of failure and new needs.⁴ Because a dignified life is one that possesses a range of opportunities for expression of the self, it is impossible for the state to account for and protect the highly specific individualized visions of each person regarding his or her pursuit of the good life. Being made aware of how the dignity of the aging person is experienced and then responding to the diversity of experiences would be an impossible task for an institution like the state to address. Therefore, the structure of capabilities is such that the freedoms of individuals are learned and assessed on the ground level and later filtered up to the institutions responsible for promoting and protecting the dignity of all persons. This inductive

³ Nussbaum, Martha. 2011. *Creating Capabilities: The Human Development Approach*. Cambridge, Mass: Belknap Press: Harvard University Press. 35.

⁴ Nussbaum, *Creating Capabilities*, 32-3.

task in discovering how central freedoms are promoted or thwarted will be addressed below in the discussion of subsidiarity, but it is worth noting that the disconnect between larger institutions and the experiences of individuals creates the need for complementary virtues-communitarian approaches that are better equipped to address the specific situation(s) of aging persons.

Nussbaum argues that humans are social and political beings who find fulfillment in others, like MacIntyre and other Aristotelian thinkers before them.⁵ Reasserting the claim that individuals are not “imagined as ‘independent,’”⁶ she remarks that the interests of the individual are bound up with the interests of others, and that individual goals are collective goals. As political or social beings, all persons depend upon other, albeit to different degrees, at every point in their lives. Third Ager, to different degrees, may need physical help, financial assistance, new opportunities for self-expression, or the companionship of which Hauerwas speaks. Regardless of the mode of assistance that the Third Ager may need, the help of others is always needed; without others, an individual simply is not able to flourish.⁷ Fluctuating levels and occurrences of asymmetric dependency are not hypothetical because, like MacIntyre, Nussbaum embraces the reality and inevitability of these experiences.⁸ However, she departs from MacIntyre in that her response recognizes the need for institutional support in enabling the good life. Because the purpose of the state is understood, in Aristotelian terms, to protect and

⁵ Nussbaum, *Frontiers of Justice*, 85.

⁶ Nussbaum, *Frontiers of Justice*, 89.

⁷ Nussbaum, *Frontiers of Justice*, 160.

⁸ Nussbaum, *Frontiers of Justice*, 87.

develop “certain core human abilities”⁹ so that all persons could live the good life, it is responsible for providing the structural means that facilitate that end. But, as was revealed above, the state alone cannot ensure that each and every individual is capable of achieving his or her vision of the good life. Even an institution directed toward meeting the needs of aging persons would be incapable of securing the possibility of the good life for all aging persons because of the diversity within the population itself and every aging person’s autonomous vision of aging well. A communitarian approach such as MacIntyre’s helps to ensure that the individualized visions of aging well are made possible, but he emphasizes the more immediate community in which one lives without attention to the structures provided by the state. MacIntyre’s communitarian vision is one that focuses on the thick descriptions of the good life that cannot possibly be adequately articulated let alone guaranteed by the state.

Nussbaum, however, appeals to individual experiences that describe the conditions of a dignified or good life, which serve as conditions to be protected by the state and its structures or institutions. Those minimum conditions are a thinner description of the good life than what comes from MacIntyre, but it is certainly thicker than Rawls’s thin theory of the good.¹⁰ In MacIntyre the fullest picture of the good life is described by the virtues of the community ‘down’ to the individual and lived within the community setting. For Nussbaum, the conditions necessary for the good life are transmitted from the individual ‘up’ to the state, and are then

⁹ Nussbaum, *Creating Capabilities*, 133.

¹⁰ Rawls, John *A Theory of Justice, Revised Edition*. (Cambridge, MA: Belknap Press: Harvard university Press, 1999), 347-350. In Rawls’s theory of justice as fairness, it is assumed that the right is prior to the good. The principles of justice, those that direct individuals toward the good, must, however, be informed by some basic ideas about the good life. The thin theory of the good functions to “secure the premises about primary goods required to arrive at the principles of justice.” When the thin theory is worked out and the basic primary good achieved, it is then possible to further pursue, on an individual basis, a fuller theory or understanding of the good. For the purposes of organizing a society, however, Rawls does not go beyond principles that address the thin theory of the good.

made the state's responsibility. Both authors, however, are attentive to the role of interdependence in living the good life. In the case of the MacIntyrean approach, interdependence is presumed within and acknowledged by one's participation in the community. In the Capabilities Approach, the state has a role in impressing interdependence through its interventions that ensure the central capabilities of all citizens. Connecting the good life to notions of dependency, communal living, and the state highlight the ways in which the good life in aging is socially mediated. Incorporating the valuable contributions of MacIntyre, other virtues ethicists, and Nussbaum into an ethics of aging requires a large framework under which both can work complementarily. Such a framework will also address the fact that aging well is socially mediated by informing and structuring the social institutions that form the Third Ager's *habitus*. A normative framework reliant upon principles can achieve this task.

Onora O'Neill takes up the question of the relationship between theories of justice and virtues in an attempt to revive their complementarity. Though some modern thinkers believe that universal concepts of justice, such as the Capabilities Approach, are incompatible with virtue theories, O'Neill suggests they are "mutually supporting."¹¹ Virtue theories do not advocate for universality given their tendency to be part of communitarian frameworks, and universal concepts of justice oftentimes lack the specificity needed for addressing the actual lived experiences of individuals. While theories of justice may be too universalist and virtues too particular, both are valuable for an ethics of aging. Their merit is revealed in O'Neill's suggestion that the real locus of ethical concern is where the two come together, namely in principles of action. Principles of action, or norms, communicate "some standard or requirement,

¹¹ O'Neill, Onora. *Towards Justice and Virtue: a constructive account of practical reasoning*. (Cambridge: Cambridge University Press, 1996), 10.

some recommendation or permission,” that when acted upon, reflect having been “guided by or shaped by that standard, requirement, recommendation or permission.”¹² They do not, however, “dominate or determine those who act on them or live by them,” or “demand uniform treatment or insensitivity to differences,”¹³ an important feature for Third Agers themselves in light of their heterogeneity, and the institutions tasked with securing the environment in which Third Agers can live well. Because the particularist virtues account of action is too limited in scope and the universalist account does not pay close enough attention to the specific “embodiments of action”¹⁴ but account for the plurality of agents and cases, the kinds of principles she argues for will be pointed but not impossible to fulfill. O’Neill argues that obligations, duties, or principles, are needed for the success of a system like the Capabilities Approach precisely because of the ways in which a culture of political liberalism interprets the Capabilities Approach as a series of rights. There are no rights without obligations for “a right that nobody is required to respect is simply not a right,”¹⁵ and the Capabilities Approach fails unless there are principles obliging a society to uphold the freedoms it outlines. Benedict XVI addressed this problem similarly:

individual rights, when detached from a framework of duties which grants them their full meaning, can run wild, leading to an escalation of demands which is effectively unlimited and indiscriminate...Duties set a limit on rights because they point to the anthropological and ethical framework of which rights are a part, in this way ensure that they do not become license.¹⁶

Loosely referring to central capabilities as rights claims is a common critique of CA, and an

¹² Onora O’Neill. “Normativity and Practical Judgment,” *Journal of moral Philosophy* 4.3 (2007): 399.

¹³ O’Neill, *Towards Justice and Virtue*, 123.

¹⁴ O’Neill, *Towards Justice and Virtue*, 71.

¹⁵ O’Neill, Onora. *Autonomy and Trust in Bioethics*. (Cambridge: Cambridge University Press, 2004), 78.

¹⁶ Benedict XVI. 2009. *Caritas in Veritate*, §43.

issue O'Neill raises with all ethical invocations of human rights claims. Her concern is that human rights claims without obligation are ideals, or aspirations, and that these claims are ineffectual and meaningless when no person or institution is required to enforce them.

If we take rights seriously and see them as normative rather than aspirational, we must take obligations seriously. If on the other hand we opt for a merely aspirational view, the costs are high...we would also have to accept that where human rights are unmet there is no breach of obligations, nobody at fault, nobody who can be held to account, nobody to blame and nobody who owes redress. We would in effect have to accept that human rights claims are not real claims.¹⁷

In this way, perfect universal duties, to be explained below, always generate a corresponding right because there is an agent obliged to act, and a claimant entitled to the good outlined by a given right.

Although O'Neill does not wish to remove rights talk from the ethical landscape, she believes that turning to obligations is the only methodologically¹⁸ sound manner in which rights can be discussed because of the aspirational problem addressed above. Principles require action, they are "obligation[s] *to do or to desist, to act or to refrain* in this or that way, in these or those situations, towards these or those others."¹⁹ Principles of action identify the obligation one agent or institution has toward another, and establish a correlative right that the right-bearer can claim. The type of right associated with an obligation is not necessarily a right to a distribution of a particular good or service, rather it is a right that leaves the allocation of goods and services to be

¹⁷ Onora O'Neill. "The dark side of human rights," *International Affairs* 81,2 (2005): 430.

¹⁸ The relationship between obligations, duties, and rights, is best understood by turning to O'Neill's method which is succinctly outlined in "Children's Rights and Children's Lives," *Ethics* 98, 1998:445-63. She pushes back against the manner in which consequentialist writers employ rights and offers an alternative constructivist approach that begins with obligations first, not rights. Her approach is "broadly Kantian" insofar as in constructing obligations identifies members of a set of universal principles of duty that would be reasoned to using Kant's concept of a maxim. See "Children's Rights" 456-459.

¹⁹ O'Neill, *Autonomy and Trust in Bioethics*, 81. Emphasis in original.

adjudicated in closer proximity to the specific case once various structures are defined. The types of obligations will be explained below, but O’Neill’s framework of obligations and corresponding duties is capable of giving teeth to the weak rights interpretation of the Capabilities Approach and complement the virtues approaches needed in adjudicating specific cases. O’Neill negotiates the complementary relationship between the universality and particularist claims in her description of different types of duties.

O’Neill classifies obligations into two categories: perfect and imperfect. Both categories are distinguished further with the terms ‘universal’ and ‘special.’ Perfect duties are those that impose a correlative right; imperfect duties do not. Perfect universal duties are owed to and performed for all. Perfect special duties are owed to and performed for specified others, and “require social structures or practices that connect specific agents to specified recipients of action.”²⁰ Insofar as these obligations and correlative rights concern Third Agers, they may look like this:²¹ *Perfect Universal* – Everybody has a duty not to thwart the dignity of Third Agers/Third Agers have a right have their flourishing promoted and protected; *Perfect Special* – Family members, physicians, and employers/potential employers have duties to care adequately for Third Agers/Third Agers have a right to sufficient care by those responsible for their wellbeing. Regarding the perfect universal duty, all individuals and institutions within society are required to protect the capacities for Third Agers to live a dignified life (as outlined by the Capabilities Approach). The perfect special duty identifies the specific relationships Third Agers have with their families, doctors, employers/potential employers who have been identified as

²⁰ O’Neill, *Towards Justice and Virtue*, 147.

²¹ This structure is adapted from O’Neill’s “Children’s Rights and Children’s Lives.”

sources of conflict in achieving the good life in earlier chapters. Imperfect duties, however, because they lack correlative rights, take a different form in practice from perfect duties. Virtues, argues, O'Neill, are helpful because they are "portable ethical characteristics"²² capable of being implemented differently in specific situations. Because imperfect universal duties are not claimable by others, they rely on the agent's character imposing an obligation, not the relationship between the agent and the would-be claimant.²³ For the aging these imperfect duties might look like this: *Imperfect Universal* – Everyone has a duty treat Third Agers with special care: no rights to what that care looks like in individual cases; *Imperfect Special* – Friends, acquaintances, coworkers, have duties to contribute to the flourishing of Third Agers: specific directives on how to contribute to the flourishing are not outlined. Third Agers benefit from imperfect universal duties insofar as they promote that attitudes of kindness, respect, and honesty be directed toward Third Agers. Imperfect special duties identify those persons with whom Third Agers have regular contact, and they encourage them to be cognizant of the wellbeing of the Third Ager and take the necessary steps in facilitating the Third Ager's good life. Imperfect duties, however, rely upon the virtuous dispositions of others and their willingness to prudentially respond to specific situations. Obligations though they may be, the imperfect duties point to the fact that perfect universal principles are not all that is ethically required in society. Precisely because of the vulnerable nature of humanity, addressed by both MacIntyre and Nussbaum, universal principles alone are incapable of generating an ethics of aging; instead they help create a more suitable space in which the good life in the Third Age correlates with the lives of others. A principled framework can better enable Third Agers to live the good life, and

²² O'Neill, *Towards Justice and Virtue*, 148.

²³ O'Neill, *Towards Justice and Virtue*, 148.

likewise, enable those who are in relation with them also to live a good, i.e. virtuous, life.

CST offers several principles capable of informing and organizing institutions and individuals regarding their role in enabling a good life for the aging. Though not the subject of subject of O'Neill's text, the principles of CST, like the obligations in O'Neill's approach, respond to "the very social links and dependence which all social relations, including just social relations, create, not merely shield but restructure;" they provide the context in which the Third Ager becomes "more *deeply, variably, and selectively* vulnerable to the action of the particular others and the particular institutions on whom" they depend.²⁴ Without principles organizing and informing the very institutions of which society is comprised, Third Agers will continue to live in relationships of asymmetric dependency, be vulnerable to the will of others, and be denied a just opportunity to pursue the good life.

Catholic Social Teaching and The Imageries of Aging

As I identified above, an ethics of aging requires an overarching structure that allows both communitarian-virtues and the Capabilities Approach approaches to work cooperatively and complementarily. On their own, both the Capabilities Approach and the virtues approaches are inadequate for an ethics of aging. The Capabilities Approach identifies and argues for a range of opportunities that will make living the good life possible; it also provides a helpful description of human dignity. Yet, the Capabilities Approach fails because it neither describes the type of action required by those who possess the full range of capabilities, nor does it consider what is required of institutional arrangements in protecting the capabilities beyond a democratic state. Similarly, MacIntyre and other virtues ethicists have blind spots: they stress the importance of accepting one's dependency and suggest that living in a virtuous community will cultivate good

²⁴ O'Neill, *Towards Justice and Virtue*, 192.

character, but they overlook the social matrix in which modern aging Americans live. Third Agers do not exist as monads, and their path to the good life unquestionably involves others, whether that be directly through support of family, friends, and doctors, or indirectly through the policies aimed at making the transition into the Third Age smoother. Nor does MacIntyre's approach account for the culture of ageism that disadvantages members of the Third Age nor does it answer the broader social-institutional questions of health, housing, and finances that Third Agers face. O'Neill's principles address the social-institutional insofar as they present the different kinds of obligations for individuals and institutions regarding structural and interpersonal interactions and responsibilities. In what follows below, I will explore how a principled approach creates the space in which the virtues and capabilities approaches can work complementarily with each other and along with the moral vision of the social ethical tradition of the Catholic Church.

In the first chapter I showed how much of the response to the question of aging well revolved around the health of an individual. From the time of Hippocrates, aging and decline in one's physical or mental health were intertwined, and this correlation bled into modern medicine and medical ethics. While clinicians may not necessarily bluntly state that aging causes a range of illnesses, the general opinion of the findings in chapter one is that aging begets decline. The answer to that decline is that the aging person should work to stay healthy by exercising and dieting, and by being proactive in one's health care. A properly functioning body and mind mark living well, a thesis that is integral to Rowe and Kahn's *Successful Aging*. However, limiting the idea of aging well to how the body and mind function reduces the Third Ager to a one-dimensional being. Such a functionalist interpretation of the person creates an image of the Third

Ager as an aging body, and or worse, as a failing machine that when fixed will function or age well. What has been shown, however, is that aging is not experienced uniformly, and that the actual health issues potentially experienced in aging are as diverse as the population. Suggesting that all aging persons should strive for a single measure of wellbeing reduces attention to the diversity of the aging population and the individual lives of aging persons. What is healthy for one person is not the same for another, regardless of age, a problem that is further confused by the fact that medicine is known to work best when it is tailored to the needs of the individual subject in his or her context. Medicine expects Third Agers to improve their health in order to achieve the good life without being attentive to the entire picture of individual wellbeing.

Theologians have responded to this broader understanding of wellbeing in many texts on health care ethics, but regarding the Third Age, there is not a cohesive voice attentive to the multidimensional nature of the good life in the Third Age beyond the common calls for dignity and the priority of the poor and marginalized. The theological vision of health care is more holistic in nature than that of medicine, but as it concerns the Third Age, the theological tradition overlooks this part of the population in favor of addressing the structures that impact other groups more traditionally discussed in biomedical ethics. Both medicine and theological ethics leave open the question of how social structures either foster or stymie one's physical and/or mental health in the Third Age.²⁵ There is an analogous response provided by the Capabilities Approach insofar as it stresses a freedom to be healthy as central to the dignified life. The freedom to be healthy is quite different than being healthy, and certainly different than an obligation on the part of others, institutions or individuals, to ensure that an individual's optimal

²⁵ There are, of course, more socially attuned responses coming from the field of public health. These will be addressed below. The conclusion reached is based only on the chapter one findings of medicine's perspectives on what it means to age well.

health is achieved. Recognition of the social factors contributing to one's health is necessary in an ethics of aging well.

However, one must not overreact to the functionalist interpretation of health and dismiss the fact that physical and mental health are integral to aging well. Defining adequate levels of physical and mental health in aging will come from continued research with aging persons, but generally should include: being ambulatory (with or without the assistance of a medical device, including orthopedic implants), having average to strong heart and respiratory function (determined by quarterly stress tests), being free from depression or anxiety, and having other chronic conditions managed closely. Guaranteeing the availability of weight loss surgery for cosmetic purposes or experimental genomic therapies and other such enhancement treatments cannot be obligatory in an ethics of aging. Ensuring adequate levels of health for the aging becomes the task of social institutions and individuals. The good life is bound to health; therefore, Catholic social ethics advocates for quality care for all persons, and especially the marginalized because of their inherent dignity. Cultivating an environment that makes possible a right to health care begins with the adoption of the principles of CST. Representative social institutions can be health care providers, insurers, health care policymakers, or any other organization that is responsible for improving the wellbeing of a patient. When health is discussed in the context of dignity, as it is in the Capabilities Approach, it becomes clear that without health a dignified life is not possible. Thus, health is integral to the perfect universal duty to not thwart the dignity of the Third Ager. The correlative right to health that comes from the obligation to treat persons with dignity is not the starting point for an ethics of aging or for CST; instead it is a corollary to the obligation to treat all individuals in a dignified manner. A social

response is necessary to ensure that every aging agent is able to age well, the specifics of which must be worked out on various levels of government and within the community. As claimants to the right to health, Third Agers must be provided acute and preventative treatments that correspond to adequate levels of health. The preventative dimension of health care includes uncovering and combatting the social causes of poor health that further complicate an aging person's ability to live the good life in aging. The obligation to ensure the health of aging persons owed by social institutions is one example of the principled approach of CST serves as a normative framework for an ethics of aging.

The second chapter shows that the good life in aging should, according to social imageries, be lived in terms of productivity and consumption, and independently. A popular myth about Third Agers is that they are not as efficient in the workplace and need more assistance (health financial etc.) than younger persons. There may be a causal link between these cultural perceptions and the medical perspectives that propose the inevitability of decline in the Third Age, and other narratives within medicine suggesting that aging is a disease; however, the information offered on healthy living itself does not appear to indicate such a relationship. Still, the belief that culture could inform the ways in which medicine is practiced and medical ethical perspectives are constructed highlights the need for a comprehensive reform. Of course, there remain other American cultural values that prove to be as influential as the aforementioned reductive views of aging well.

As a cultural value, the influence and importance of independence cannot be overstated. A detailed history is provided in the second chapter, but it is worth recalling that autonomy is largely interpreted as individualistic independence or simply as the freedom of choice, which is

concretized as a popular feature of American identity. Autonomy is a value promoted in both medical and Catholic ethics, but neither of those disciplines privileges the type of individualistic interpretation that is made manifest in American cultural imageries of aging well – imageries that do not create the space for positive interpretations of dependence or interdependence. MacIntyre responds directly to the problems raised by overemphasizing a libertarian interpretation of autonomy, but it is the Catholic social ethical tradition that responds more comprehensively through its principles of dignity, solidarity, subsidiarity, and the preferential option for the poor and marginalized. Each principle reminds all individuals, regardless of age, of the fundamental importance of human sociality and its role in living the good life, interdependence, and the mutual goals of the human family.

Regarding the Third Ager's economic life, the consumer-capitalistic system provides two incompatible ideas. First, American consumer culture is such that individuals are told to acquire or consume goods (i.e. material possessions for the purposes of expressing oneself and procuring medical treatment to look/feel younger) in order to live well. Second, the ageist tendencies within the capitalistic society suggest that aging persons are not as productive in the workplace (i.e. unwilling to adapt, physically slow at completing tasks) resulting in being pushed out of work more easily. These are irreconcilable ideas because in order for the aging person to acquire various consumer goods, he or she must have the financial means; however, being pushed out of the workplace because of negative cultural perceptions limits an aging person's ability to earn and/or save the money necessary to consume goods in the marketplace. Regardless of the aging person's financial security, the financial resources needed to satisfy the mercurial consumer vision of the good life in aging exceed the means of a majority of Third Agers. Although a

financial support program like Social Security exists, its intention was never to provide enough supplemental income to facilitate the consumer habits of Third Agers. However, the problem is not with the type of life made possible by Social Security, but rather that Third Agers are simultaneously discouraged from working and pressured to spend their money imprudently. There continues to be debate about the function and importance of Social Security, and who is obliged to contribute to Social Security and why they are obliged to do so. Overcoming the consumer psyche is not easily achievable, but the principle of solidarity and a distinct principle of intergenerational solidarity, whose focus is on a particular demographic, can begin this process. What the public debate about Social Security points to, however, is a broader thematic problem of the American capitalistic consumer culture.

Debating the value of Social Security exemplifies the threat to aging well imposed by individualism and a fear of dependency. An unwillingness to support aging persons through contributions to welfare programs like Social Security demonstrates the disconnect between perfect universal duties and imperfect universal duties. At the very least disagreeing with the idea, not the tax-cost structure, of Social Security indicates a lack of compassion that signals the importance of O'Neill's imperfect universal duties. Working to undermine Social Security, on the other hand, actively denies the dignity of the aging person by inhibiting their freedoms through financial constraints, and thus contravenes the perfect universal duty to not thwart the dignity of Third Agers. The general public questioning of whether or not there is an obligation to contribute to Social Security highlights a fundamental misunderstanding of one's sociality and the need for principles that incorporate and inculcate the realities of sociality and dependency. Family and friends of Third Agers may also fall short of fully embracing a program like Social

Security because of the ways in which dependency is culturally disparaged. Surely, this is an instance in which those who are assumed to have imperfect obligations to Third Ager need both a principled framework and further training in virtue. The principles of CST achieve both tasks, but not without the support from the Capabilities Approach and communitarian-virtues approaches.

On a broader level, this reduction of the aging person to producer or consumer points to how Third Ager are further provided with individualistic responses to the question of aging well. The economic dimension of aging well requires that the Third Ager have enough, where enough is determined by fluctuating cultural trends that precipitate new ‘needs,’ money to live the good life. The message communicated through the marketers and advertisers of consumer culture is that aging well is relevant to the affluent only, but this cannot be the model for a population whose demographics do not match the message. Aging white men and women are more likely to have the means to purchase consumer goods and elect for cosmetic surgeries billed as bringing about a better life. A majority of Third Ager of color who have earned less money throughout their lives will not, however, have the financial access to such consumer goods. For example: A Third Ager of color may be confronted with paying for the long-term effects of a lifetime of discriminatory treatment within the healthcare system in addition to new care needs. Here again, the social dimension of the aging person’s experience is neglected entirely. For the affluent white individual capable of responding to the changing visions of aging well emerging from consumer culture, the presumption is that he or she has should live the good life one his or her own, independent of others. For persons of color there is no recognition of what has contributed to their needing different types of care than their white affluent

counterparts, or why their opportunities for living the good life are stifled by correlative financial burdens. In both cases, there were and continue to be social institutions or policies and cultural norms that have worked synergistically with some demographics and antagonistically toward others regarding their pursuit of the good life. This further reveals the faults with not having a principled approach to an ethics of aging; CST provides principles that do not allow institutions or individuals to overlook the problems that led to the state of the Third Ager of color mentioned above.

Finally, the principled framework provided by CST offer a comprehensive foundation for a theological ethics of aging. When treated as perfect and imperfect, and universal and special obligations (using O'Neill's interpretation of Kant's terms), the principles inform and direct policies, organizations, and the behaviors and attitudes of citizens. The principles hold society and its structures responsible for the good life of the aging. The freedoms articulated in the central capabilities are integral to human dignity and the inductive method provides the institutions responsible for ensuring the good life in aging instruction on what is essential to aging well. MacIntyre's communitarian thinking provides guidance for the specific practices that contribute to an aging individual's living of the good life. CST and its principles support the autonomy of the individual while also recognizing an individual's matrix of relationships and responsibilities. The principles are universal in their applicability, but because of their focus on sociality they can speak specifically enough to particular situations and relationships. An ethics of aging requires a principled framework in order to address the conflicting visions of living well mediated through the social imageries without inhibiting the autonomy or sociality of the Third Ager as individual.

Why Catholic Social Teaching

Interpreting the principles of CST as obligations and not simply themes that appear in the CST literature augments how Catholics are called to act, and how Catholic institutions are rendered. However, understanding these obligations in the terms set out by O’Neill would mean a much wider application of CST than just the Catholic tradition; what may have previously been imperfect universal obligations are to be made perfect universal obligations. According to the *Compendium of the Social Doctrine of the Church*, the principles are “primary and fundamental parameters of reference for interpreting and evaluating social phenomena, which are the necessary source for working out the criteria of discernment and orientation of social interactions in every area.”²⁶ Neither are they empty formal claims nor are they particular to Catholic enclaves. As principles of action they call upon all persons to perform or abstain from performing certain acts; they challenge the conscience of all persons to act responsibly “with all people and also regarding all people.”²⁷ Specific examples of how the principles can be used in tandem with the Capabilities Approach and virtues approaches in formulating an ethics of aging will be explored below.

The social ethical tradition of the Catholic Church has a rich history beyond its commonplace perception as a collection of papal and episcopal statements. As *Gaudium et spes* explains, the Church is called to respond to the signs of the times, to address the Church’s relationship to the world, and the faith and daily lives of believers. Such a response is witnessed in biblical exhortations regarding justice in the community, Augustine’s articulation of the

²⁶ Catholic Church. Pontifical Council for Justice and Peace. 2004. *Compendium of the Social Doctrine of the Catholic Church*. Vatican City; Washington, DC: Libreria Editrice Vaticana. §161.

²⁷ Pontifical Council for Justice and Peace, *Compendium*, §163.

relationship between Church and State in *City of God*, and Thomas Aquinas' re-formation of Catholic moral theology in the *Summa*. Charles Curran describes Industrial Revolution-Era CST as influenced by

teaching in Scripture...Catholic attitudes toward socialism and the Enlightenment, a Catholic tendency to look to the Middle Ages as the golden period of human existence, and revived interest in the philosophy and theology of Thomas Aquinas.²⁸

Certain anthropological, political, and economic claims were developed that informed the principles of CST.²⁹

Two of these claims evidenced throughout CST are the dignity and social nature of the person.³⁰ As described by Aquinas, dignity refers to the person's being created in God's image and likeness. Whereby image and likeness mean that, like God, the person has "intellect, free will, and the power of self-determination."³¹ All persons are bestowed equally with such dignity through "the generous gift of creation and redemption from God."³² A second essential part of the human is his or her being social. Individuals need "the social ties of family, associations, and political community for their proper development."³³ As created to live socially and politically, the image of the person emerging from CST overturns the myth of being self-made and accepts dependence as an essential part of being human. *Gaudium et spes* identifies the importance of

²⁸ Curran, Charles E. *Catholic Social Teaching: A historical theological and ethical analysis*. (Washington: Georgetown University Press, 2002), 6-7.

²⁹ The first official document considered to be part of the CST canon is Leo XIII's *Rerum Novarum*, published in 1891.

³⁰ In Chapter Four, these were discussed using Margaret Farley's terms "obligating features of personhood." Farley, however, discusses dignity in terms of autonomy. See: Chapter Four, pp 190-192.

³¹ Curran, *Catholic Social Teaching*, 132.

³² Curran, *Catholic Social Teaching*, 132.

³³ Curran, *Catholic Social Teaching*, 133. Summarizing *Gaudium et spes* §24-25.

social structures and institutions as integral in the flourishing of both individuals and the community.³⁴ Thus the responsibility of the political order is such that is to protect the dignity of individuals insofar as they are enabled to live the good life or flourish. That political order itself is “a natural society that is based on the social nature that the Creator has given to human beings,”³⁵ and has the moral responsibility to direct people to their own and the common good. CST’s understanding of the state’s purpose then is to avoid the extremes of individualism and collectivism, for the former denies the sociality of the individual and the latter subordinates the authentic development and good of the individual to the whole. Curran describes the state’s role in promoting the common good as one of mutuality: “the common good ultimately flows back to the good of the individual and thus brings together the good of the community and the good of the individual.”³⁶ Integral in the state’s ability to fulfill its purpose and the individual’s dignity and social nature being respected is the economy. Cautions against individualism in the economic sphere take the form of condemnations of materialism, explications of workers’ rights and workers’ responsibility to contribute to society, and critiques of socialist economic systems that diminish the dignity of the individual. Privately held goods are important, but possessing them to the detriment of others is immoral. Working to meet basic needs is commended, but work for the pursuit of consumeristic ends undermines one’s relationship with others and God. Though the CST position on the economy is referred to as a third way between capitalism and socialism, CST prefers capitalism so long as it “recognizes the fundamental and positive role of

³⁴ *Gaudium et spes*. §25. Within the section entitled “The Interdependence of Person and Society” the conciliar document addresses the development of persons, called ‘socialization,’ which is facilitated by institutions that increase and protect the rights of persons.

³⁵ Curran, *Catholic Social Teaching*, 138.

³⁶ Curran, *Catholic Social Teaching*, 145.

business, the market, private property and the resulting responsibility for the means of production as well as free human creativity in the economic sector.”³⁷ This point will be explored below in the discussion of working in the Third Age. The anthropological, political, and economic themes that emerge from the various CST documents work collectively to ensure that dignity, the common good, and justice are integral to the individual and communal life of the Christian, but there is much more to be said about these and other principles in regards to the current socio-cultural context of aging persons today.

“The Church sees in men and women, in every person, the living image of God himself,”³⁸ reads the foundational explanation of dignity in CST. Established in creation and confirmed through the Incarnation, the human person is capable of self-knowledge, self-determination, and called into relation with God and other persons. The creation of the person is understood as an act of love, an act of love that initiates the covenantal relationship between God and persons. In response to that relationship, persons are called to love and pursue a relationship with God, and God’s creation. The love command and the response to it, as outlined by Frits de Lange in Chapter Three, causes the agent to recognize and respond to the obligating features of personhood, dignity and sociality. Recognition of the equal dignity of all “regardless of their race, nation, sex, origin, culture, or class,”³⁹ is what makes possible the common and individual growth of all. Respecting, honoring, protecting, and fighting for the dignity of all persons are obliged by this feature of personhood. However, O’Neill’s use of universal and special principles signals that such a vague ‘dignity for all’ message does not carry enough weight; An approach

³⁷ John Paul II. *Centesimus Annus* §42.

³⁸ Pontifical Council for Justice and Peace, *Compendium*, §105.

³⁹ Pontifical Council for Justice and Peace, *Compendium*, §144.

that moves beyond a cheap invocation of dignity is Nussbaum's Capabilities approach for it provides a more concrete explication of dignity that is particular to a social context and the experience of individuals. What promoting the dignity of Third Agers means, in light of the O'Neillian principles applied to CST and Nussbaum's capabilities as a normative anthropology for the dignified life, must be considered.

Insofar as biomedical ethics combines end-of-life issues with aging persons, promoting the dignity of the aging person would mean greater attention from biomedical ethicists and medical practitioners regarding the needs of Third Agers. The implications are as follows: first, there must be a concerted effort in biomedical ethics to disassociate the elderly or those perceived to be near the end-of-life because of their age from the members of the Third Age. A turn to the gerontological literature that speaks specifically to the distinctions is helpful in completing this task so that aging persons are treated as the unique group they are. Of course, the potential pitfall of generalizing the condition and needs of all Third Agers, the same as any other demographic grouping, must be avoided. On this point the work of medicine as a whole can assist in easing the language of 'aging as disease' in such a way that medical practitioners do not assume a given condition is the result of a patient's age or that simply because the patient is in the Third Age that he or she should expect to fall victim to conditions x, y, and/or z. Improving the communication between practitioner and patient is the first step in establishing a more respectful relationship between the two. In the age of the Internet, it is incumbent upon medical professionals to ease the woes for aging persons who may have read about a condition and fall into the trap of self-diagnosing based on ageist claims. The medical professional is also responsible for caring for the person beyond a medicinal healing by mollifying the fears Third

Age patients may have about their health. A role in easing the transition into the Third Age is also the responsibility of gerontologists given their emphasis on the inherent value of aging itself. If their claims about the goodness to be found in the developmental process of aging are accurate, more work must be done to show aging persons what that goodness is and how it is to be found or experienced.

Additionally, the dignity of the aging person demands the end of discriminatory practices broadly within American culture, and specifically within the workplace. Hiring and firing practices perpetuate biases against aging persons, yet the modern economic situation of most aging Americans is such that they cannot afford to be subjected to such unfair treatment, as well as it being a slight to their dignity. Many aging Americans need to continue to work in order to pay for their housing, health care, and to make possible the type of retirement life that they envision. In addition to those basic responsibilities, some individuals may have other obligations to family members that preclude them from fully retiring. The economic ramifications are but some of the damaging effects when it comes to workplace discrimination – being treated in an unfair and undignified way is the more crushing experience. Work is bound to dignity because it is an expression of the self. Without being able to express oneself, achieving the good life becomes impossible.

As John Paul II explains, work is good for individuals because it is a mode of self-expression; work honors the dignity of person.⁴⁰ The moral significance of work outlined in *Economic Justice for All* is threefold: it enables individuals to provide for their material needs, it is a form of self-expression, and is the primary way in which one contributes to the good of the

⁴⁰ John Paul II. 1981. *Laborem Exercens*. §9.

community; it is work's status as "a principal way that people exercise the distinctive human capacity for self-expression and self-realization"⁴¹ that makes it an essential consideration for an ethics of aging. Institutional structures, such as mandatory Social Security collection, that make working in the Third Age more difficult are not wrong simply because of their discriminatory premises, but also because of the impact that such institutional directives have on our culture and, of course, on the Third Ager. Policies that mandate Third Agers retire in their 60s and collect Social Security benefits, even if they continue to work in which case they are subjected to penalties,⁴² deny Third Agers the right to work, to which other members of society are entitled. The policies close off the opportunity for individuals to fulfill their responsibility to imitate God.⁴³ This discriminatory practice is a fundamental violation of their dignity that, when mediated through our culture, finds traction in mythical claims, for example, about the inability of Third Agers to positively contribute to the workplace and the society. When the Third Ager is pushed out of or unable to reenter the workforce, the real injustice of the institutional policies is revealed: the very worth and identity of the Third Ager is undermined. Inhibiting the expression of the self through work goes against cultural norms that esteem individualism and personal responsibility in living the good life – society simultaneously defines the Third Ager by his or her productivity while removing opportunities for him or her to work. Similarly, the cultural images suggesting that the Third Ager is less productive deny work's role in enabling individuals to contribute to the flourishing of the community.

⁴¹ United States Conference of Catholic Bishops. 1986. *Economic Justice for All*. §97.

⁴² These penalties are assessed based on a Social Security recipient's earnings while working and collecting Social Security benefits are paid back directly to the SSA or through the IRS on personal income taxes.

⁴³ *Laborem Exercens*, §25.

In addition to these issues the Third Ager faces the ancillary impediments to living well mediated through the norms of consumer culture. The first characteristic of work's moral dimension, being able to provide for one's material needs, becomes increasingly difficult for Third Agers who are not given the opportunity to continue to work. Acquiring material goods, as addressed in Chapter Two, is part of consumer culture's message to Third Agers that the more goods that can be possessed the *better* kind of life that individual is living. Without the means to meet the shifting needs generated by consumer culture, the Third Ager will be trapped in an unending cycle, never able to satisfy culture's image of aging well. Worse will be the demoralizing realization that the pursuit of consumer culture's images of aging well was inauthentic and potential detrimental to the Third Ager's flourishing. The Third Ager has limited institutional or structural support to meet the impossible demands of consumer culture's images of aging well, and culture perpetuates norms that further demoralize and devalue Third Agers. Ageism impedes the good life in the Third Age on institutional, cultural, and personal levels as witnessed by the workplace. Its presence reveals the failures of social institutions, communities, and individuals to recognize how essential having opportunities to be included in all sectors of social life is for the good life in the Third Age. Injustices imposed upon Third Agers are representative of the need for several CST principles: solidarity, subsidiarity, participation, the preferential option for the poor and marginalized, and intergenerational solidarity or justice. Exploring these principles and their roles in an ethics of aging follows below.

The Principles Of CST And The Third Age

Benedict XVI acknowledges the ways in which certain cultural narratives thwart the authentic development of individuals, and calls for a conversion on the personal and institutional

level in *Caritas in Veritate*. Though he does not identify the US specifically, Benedict explains that “there are certain cultures in the world today that do not oblige men and women to live in communion but rather cut them off from one other in search for individual well-being limited to the gratification of psychological desires.”⁴⁴ Reinforcing MacIntyre’s claims about dependency, relationality, and living the good life in community, Benedict affirms that the Christian vision of humanity is one that presupposes a vision of the person in which relationality is essential to the good life. The principle that speaks to honoring the dignity and sociality of the individual is solidarity.

First and foremost, solidarity is a “sense of responsibility on the part of everyone with regard to everyone;”⁴⁵ it is a perfect universal principle, whether we are discussing Third Agers or not. Solidarity is a principle that acknowledges the interdependence of persons and “the common path of individuals and people towards an ever more committed unity.”⁴⁶ It requires that all persons commit themselves to the “good of all and of each individual,”⁴⁷ because “the more authentically he or she lives these [interpersonal] relations, the more his or her own identity matures.”⁴⁸ Such a task reveals solidarity’s ability to serve O’Neill’s approach to principles well: it is a principle that obliges institutions and persons to act that is also capable of cultivating the dispositions necessary for imperfect obligations. Solidarity is not merely “a feeling of vague compassion or shallow distress at the misfortunes of so many people,” but rather the active

⁴⁴ *Caritas in Veritate*, §55.

⁴⁵ *Caritas in Veritate*, §38.

⁴⁶ Pontifical Council for Justice and Peace, *Compendium*, §192.

⁴⁷ John Paul II. 1988. *Sollicitudo Rei Socialis*. §38.

⁴⁸ *Caritas in Veritate*, §53.

pursuit of “the good of one’s neighbor with the readiness...to lose oneself for the sake of the other,”⁴⁹ to serve instead of oppress. John Paul II’s words reflect the very nature of solidarity as a proactive principle of action, not an empty formal principle meant only to inspire an reactive empathy.

Moreover, solidarity speaks to the role of social institutions in the flourishing of individuals and the community. It “determines the order of institutions”⁵⁰ thus, practicing solidarity means identifying the social structures that systematically thwart authentic development or the pursuit of the good life and transforming them into complementary rather than antagonistic forces in the lives of individuals and the community. Benedict, like John Paul II and Paul VI before him, criticizes the ways in which modern economic practices have alienated individuals, peoples, and nations. Because the “economic sphere is neither ethically neutral nor inherently inhuman,”⁵¹ and because every economic act has a moral consequence, many of the political and social structures to be shaped by solidarity are directly linked to an individual’s economic activity. Thus, the principle of solidarity obliges “appropriate modification of laws, market regulations, and juridical systems”⁵² to ensure aging persons are given comprehensive opportunities to live the good life.

Solidarity as a virtue (understood, in O’Neill’s terminology, as an imperfect duty that overlaps with virtues) can be witnessed in MacIntyrean communities, and demonstrated by virtuous individuals who view solidarity as an imperfect universal duty. In health care, the

⁴⁹ *Solicitudo Rei Socialis*. §38.

⁵⁰ Pontifical Council for Justice and Peace, *Compendium*, §193.

⁵¹ *Caritas in Veritate*, §36.

⁵² Pontifical Council for Justice and Peace, *Compendium*, §193.

principle of solidarity signals a paradigm shift. The principle of solidarity identifies the obligations that health care institutions have toward caring for all persons. A solidaric view of health care support a system provides services to all regardless of ability to pay or insurance. Because health is integral to living well, and there is a duty not to undermine the dignity of the Third Ager, the health care system must attend to the needs of all Third Agers and ensure that their care plans are such that individuals are enabled to return to adequate levels of health. However, the solidaric vision of health care goes beyond acute care settings and compels reforms within preventative care services. As such, institutions are obliged to work to improve the quality of health care rather than disproportionately focus on curative medicine. For the aging this means abandoning life extension therapies in favor of improving the quality and distribution of health care to Third Agers. Similarly, the solidaric vision of health care compels institutions to moderate what Richard McCormick calls the “interventionist mentality,”⁵³ that causes medicine to solve health problems with technology instead of investigating and correcting their root causes. Prescription drugs are first line treatments for many conditions, but there may be times that a symptom described by an aging person is innocuous; however, because of ageist tendencies, the reaction may be to prescribe a medication to treat a condition to which the symptom is linked. As a patient, a Third Ager may present with vitamin deficiencies, but a vitamin supplement does not address the shortcomings of his or her diet. Certainly, the vitamin does not explain why there are deficiencies in the diet. Identifying the health care needs of Third Agers requires work from within the communities, thus it is necessary that the solidaric vision of health translate into a virtue of solidarity that supports the imperfect obligations owed to Third

⁵³ McCormick, Richard. SJ. “Hidden Persuaders: Value Variables” in *Corrective Vision: Explorations in moral theology*. (Kansas City, MO: Sheed and Ward, 1994), 173.

Agers. Still, the needs may exceed the resources available within the community – resources here do not only mean actual medications or medical devices – therefore, the cooperation between larger social institutions and smaller community organizations is imperative. However, being able to appeal to larger institutions is what enables smaller or local organizations to function as well as they do. The CST principle that identifies this relationship is subsidiarity.

One of the few principles that speaks directly to the organizational structure of social institutions, subsidiarity can be found in a majority of CST documents. Subsidiarity obliges smaller social organizations to work for the promotion of the good life of individuals under their care with the provision that larger organizations provide support if necessary. On one hand the state proper is to refrain from “anything that would de facto restrict the existential space of the smaller essential cells of society,” while on the other hand “economic, institutional, or juridical assistance” is to be offered to the smaller cells of society as needed.⁵⁴ Subsidiarity establishes a method for organizing the institutional arrangements necessary for the facilitation of solidarity, participation, intergenerational solidarity, and the preferential option for the poor and marginalized. It bridges the gap between the particularist communitarian-virtues approach to the good life and the universalist theories: as a principle, it is universalist, but because it turns to the specific cases, it requires the specificity and practicality afforded by virtues that cannot be captured in a purely formal principle. In addition to the space for the procedural implementation of other necessary principles for an ethics of aging, the principle of subsidiarity works well to create the space in which the freedoms of Third Agers outlined in the Capabilities Approach can be acted upon while having the ‘checks and balances’ nature to identify when Third Agers are

⁵⁴ Pontifical Council for Justice and Peace, *Compendium*, §185.

not fully enabled to exercise their central capabilities.

Subsidiarity obliges the “respect and promotion of the human person and the family,” the “encouragement of private initiatives so that every social entity remains at the service of the common good,” “safeguarding human rights and the rights of minorities,” “bringing about bureaucratic and administrative decentralization,” and “appropriate methods for making citizens more responsible in actively ‘being a part’ of the political and social reality of their country.”⁵⁵

Community models that counter the individualistic narratives of consumer culture are able to identify and respond to the immediate needs of local constituents. If the community cannot respond to needs, it is protected by the obligation of larger organizations to assist in meeting those needs. Smaller social units or organizations can be better equipped at identifying and answering what aging persons need in order to flourish using a method such as Community Based Participatory Research (CBPR).⁵⁶ CBPR is primarily used in public health as a means for members of the community to volunteer information without the fear of a hidden agenda from an outside researcher, and often proves to be helpful in uncovering authentic needs of community members. A broader use of such a method bolsters the description of dignity found within CA, and provides genuine feedback as Third Agers experience changing life conditions. Emphasis on specific cases can ensure that local needs are met, that those needs are brought to the attention of

⁵⁵ Pontifical Council for Justice and Peace, *Compendium*, §187.

⁵⁶ Community based participatory research is a research practice that attempts to stifle the misuse of community trust and instead emphasizes the importance of and need for action to be taken on behalf of the community for the community. CBPR “challenges researchers to listen to, learn from, solicit and respect the contributions of, and share power, information, and credit for accomplishments with the groups that they are trying to learn about to help.” In a 2004 article, Dr. Meredith Minkler stated that “CBPR represents an orientation to inquiry that is highly consistent with the principles of public health education and ‘public health social justice,’” and that the practice “underscores ethical principles such as self-determination, liberty, and equity” which demonstrate the idea that individuals are capable of assessing and expressing their health needs without the help of a voice external to the community. See: Horowitz et al. *Community-Based Participatory Research from the Margin to the Mainstream*. 2634; Minkler, Meredith. *Ethical Challenges for the ‘Outside’ Researcher in Community-based Participatory Research*. 684

larger groups so as to inform other smaller communities about potential needs, and, in the event of the local needs not being met, the responsibility for care can be given over to larger social institutions. Ideally, the principle of subsidiarity ensures, on multiple levels, that aging well is facilitated.

Organizations with more resources or capital are not necessarily better equipped to identify and address the needs of all Third Ager, but they may very well be better at correcting systemic issues that have precipitated those very needs. Surely, an appeal to the highest levels of government should not be the first step taken when moving from a relatively small social group to a larger institution, so there must be effective intermediary institutions ready to protect and promote the good of the aging individual. Publicly funded municipal or regional groups that have the facilities and resource staff can provide aging persons with the types of space they may need to pursue various avenues of fulfillment (i.e. recreational and social opportunities). According to the CDC, in 2014 there were 4800 adult day service centers that provided social activities, transportation, meals, personal care, and therapeutic activities, but they focus exclusively on persons with more serious health needs than the average Third Ager.⁵⁷ Such facilities are important, but they do more to separate older adults from the community than integrate them with other non-peers. Though other types of community centers exist in and around many popular urban areas, community centers face a similar problem of separating programs into age groups instead of actively working to promote a truly communal life. Community centers do well to focus on youth recreational sports, provide fitness facilities, and offer ‘senior citizen’ programs, but a message of communal unity and support is necessary to cultivate the virtues that

⁵⁷ According to the CDC, 44% of the 4800 centers were for-profit institutions, suggesting that only those who are financially secure enough were eligible for such services. Accessed February 23, 2017. <https://www.cdc.gov/nchs/fastats/adsc.htm>

support imperfect universal obligations vis-à-vis Third Agers. Cultivating this sense of community begins with making access to the center easier, both financially and in terms of transportation; it continues with offering programs that bring the various constituencies together. It is important that Third Agers be distinguished from ‘senior citizens’ within these centers because of the ways in which stereotypes about senior citizens inaccurately reflect the experience of the Third Age. The Berkshire South Regional Community Center (BSRCC) of Great Barrington, Massachusetts is a model for such centers because it outlines a mission to “connect, encouraging all to build a sense of community, and common purpose,”⁵⁸ with free and paid program offerings for early childhood, school-aged children, teens, adults, and senior citizens.

The center offers up to a 75% discount on membership fees if individuals cannot afford the yearly dues⁵⁹ in an effort to make the center accessible to as many people as possible. BSRCC offers a specific program on how Third Agers might handle the changes that come with the aging process. Relevant to the consumer experiences of Third Agers, BSRCC offers educational workshops that address fraud, identify theft, and other popular consumer scams to which aging persons may be subjected. While the list of programs for Third Agers goes on, BSRCC’s mission to create a sense of community and make all feel like they belong somewhere, particularly those who are experiencing changes in their lives, is exemplified in the simplest of programs: weekly community dinners. Open to all, the dinners are an opportunity for intergenerational interaction among the community members. Though the dinners may be short, they present inviting opportunities to cultivate intra- and intergenerational friendships. Companionship is as important in aging well as maintaining one’s health; therefore, having an

⁵⁸ Accessed February 23, 2017. <http://berkshiresouth.org>

⁵⁹ Yearly dues for adults up to age 64 are \$672, and \$612 for those over 65.

organization capable of meeting both sets of needs is integral for aging well. However, what BSRCC and other community centers in more rural areas might not be able to address is the problem of transportation. Many community centers serve an urban or suburban area that either has adequate transportation infrastructure in the case of the former, or a population that has access to reliable transportation in the latter. Ensuring that members of the community can make use of the services provided by the center is, of course, an issue, but getting to and from the community center points to the larger transportation infrastructure problems created by the shift from rural to urban to suburban life. Reliable access to a motor vehicle enables aging persons to pursue various secondary goods integral to their visions of the good life, but not all Third Agers can afford to own, lease, or rent cars, or hire car services. Addressing this issue requires work beyond the scope of this dissertation, but its role in enabling the fulfillment of the good life in aging is important for many Third Agers.

Although community centers are helpful, they are not equipped to effect the type of change in the health of Third Agers that larger health-specific institutions can. The support of more organized, structured, and efficient institutions is necessary to ensure that the needs learned in communication with the aging do not go unaddressed. As the health care needs of aging persons change throughout the Third Age it is necessary that larger social institutions with broader reach, more resources, and weightier political influence are able to resolve health issues impeding an individual's good life effectively. One such organization that collects the needs of various smaller communities is Catholic Health Initiatives (CHI), which has a community benefit program designed to improve the overall health of the community through an "organized and measured approach to meeting identified community health needs or increasing access to health

care.”⁶⁰ The mission of CHI, however is admittedly informed by a larger organization, the Catholic Health Association (CHA). The CHA works to spread the Catholic mission and vision not only by augmenting health care practice or delivery but also by engaging in broader sociopolitical concerns relevant to individual and population health.⁶¹ The work of both these organizations is effective in bringing attention to the needs of vulnerable populations and effecting a positive change in overall health. However, the specific attention to health care delivery can overshadow the other relevant factors in one’s health. Limiting subsidiarity’s reach to making sure that health needs are identified and treatments made available still falls short of truly improving the wellbeing of aging persons. As important as health is in one’s being able to age well, the way in which health is thought of must be reexamined in light of the social experience of aging.

Improving the health of aging persons has been the focus of certain initiatives in recent years. Pneumonia and flu vaccinations are more popular and available than they were a decade ago, but these two pathologies are not necessarily the leading causes of health decline in aging persons; however, they fit the narrative of aging as disease or aging as inevitably diseased, thus any efforts to curb them seems like the type of targeted care for which larger institutions are responsible. Policies directed at vaccination or other type of preventative care are vital to the

⁶⁰ Catholic Health Initiatives. *Community Benefit*. Accessed February 27, 2017. <http://www.catholichealthinitiatives.org/community-benefit>. In 2015 CHI’s community benefit program contributed \$1.61 billion to the community health care needs across CHI’s network of hospitals. The only statistic indicative of resources directly impacting members of the Third Age is CHI’s Medicare-related contribution: \$629 million.

⁶¹ The CHA’s most recent publication, “Improving the Lives of Older Adults through Faith Community Partnerships: Healing Body, Mind, and Spirit,” continues in the tradition of presuming declining health for most members of the Third Age. However, the CHA calls upon clergy to more actively check-in on the health of parishioners, for clergy and parishioners visit individuals who live alone and/or who are sick, and for parishioners to train in caring for elderly persons, all of which are within the scope of the principles of CST. The CHA also asks that hospitals or health care organizations host programs in parishes or congregation spaces, interview clergy and parishioners to better assess the health of the vulnerable population, and to be more open to clergy or clergy-in-training having a more active role in the hospital or health care organization itself.

flourishing of aging persons, but public health has a unique role in not only addressing the actual conditions affecting an individual, but also the co-determinants of health integral to the good life. Public health's identification of the social determinants of health supports the idea that the very experience of the good life is socially mediated, thus requiring a response beyond the individual. One's environment (i.e. air and water quality, proximity to safe exercise spaces or opportunities to walk/run), access to health care, availability of and ability to procure the healthy foods necessary for achieving optimal health, and a number of other factors contribute the health of an individual. However, these issues are not germane to medicine. Responding to them requires a systemic effort to improve the overall wellbeing of aging persons. Improving the wellbeing of aging persons helps them to age well by making their continued involvement in communal life possible. Without emphasis on the complex situation of actual individuals it is possible that another principle of CST is overlooked, namely participation.

Participation is articulated in Paul VI's *Octogesima Adveniens* (1971), in which he issued a call to action for all Christians: take up your personal responsibility in solving the various injustices facing individuals worldwide. Paul follows a pattern of placing the onus on the individual to shoulder the burden of fixing the world's problems, which for Paul were the growing economic disparities between the global North and South. But for many, there simply is no ability to participate, which makes personally responding to injustices rather difficult if not impossible. However, these glaring objections to Paul and the Church's position cannot overshadow the message of participation. Reasserting the importance of human sociality and interdependence, the principle of participation presents itself as "the greatest aspiration[s] of the

citizen,”⁶² and central in the continuation of the Church’s preferred political system, a participatory democracy.⁶³ Participation refers to “a series of activities by means of which the citizen, either as an individual or in association with others, whether directly or through representation, contributes to the cultural, economic, political and social life”⁶⁴ of the community. Such contributions promote the good of the individual and the community and are the very purpose of civic life. Participation facilitates the authentic development of each community or country “in a framework of cooperation free of domination, either economic or political,”⁶⁵ where development refers to an individual or entire nation’s ability to pursue the good life free from systemic structural impediments. Being able to participate presumes the conditions outlined in the Capabilities Approach as the combined capabilities are the freedoms that enable individuals to do and be across a range of categories. Thus, at the very least participation requires adequate health, and maximally, demands assistance in being given a voice in the local, regional, and national political conversation. As Chapter Two showed, policies have a tremendous impact on Third Agers’ ability to live the good life, therefore they should be empowered to inform political conversations that immediately impact their lives. For those who cannot attend town council meetings or get to the polls on election days, or those who are uninformed about various policies, efforts should be made to ensure participation through

⁶² Pontifical Council for Justice and Peace, *Compendium*, §190.

⁶³ A participative democracy “means that the different subjects of civil community at every level must be informed, listened to, and involved in the exercise of the carried-out functions.” Pontifical Council for Justice and Peace, *Compendium*, §190.

⁶⁴ Pontifical Council for Justice and Peace, *Compendium*, §189.

⁶⁵ Christine E. Gudorf. “Commentary on *Octogesima adveniens (On the Eightieth anniversary of Rerum novarum)*,” in *Modern Catholic Social Teaching: Commentaries and Interpretations*, ed. Kenneth R. Himes, O.F.M (Washington: Georgetown University Press, 2005), 316.

transportation and/or communicating information. Participation also hinges on a shift in the cultural perception and treatment of aging persons regarding ageism. Without an effort to adjust policies and cultural sentiment that negatively impacts aging persons in the workforce, Third Agers will not be able to participate in society, which includes being a producer and a consumer, as they see fit. Because one's value is closely tied to one's work, denying individuals the right to express themselves through work effectively denies them the ability to participate in society. As one ages and continues through the stages of development, he or she may find new passions, but, because of ageist policies and practices, he or she may not be able to pursue them. This extends beyond the workforce to adult education programs. On the rise at community colleges and satellite programs offered through municipal school districts, education programs for Third Agers can be helpful in providing a social space or opportunities to pursue interests. However, for those who wish to start down a new work path, they may find their efforts are futile given the prevalence of ageism in the workplace. Participation is social, political, and economic, and avoidable shortcomings in any of those areas impede the authentic development or genuine pursuit of the good life. Participation in CST was historically contextualized by the growing economic divide between the developed and developing worlds, and a commensurate principle emerged that spoke to that experiences of economic, social, and political, deprivation.

The first cohesive invocation⁶⁶ of the principle of preferential option for the poor, and correlative birth of liberation theology, came during the 1968 Conference of Latin American Bishops at Medellin. In response to the rising social and political tensions spurred on by the

⁶⁶ "Preferential option for the poor" appears as a nascent idea in Paul VI's *Populorum Progressio* (1967). In §12-21, Paul VI lays the groundwork for the option by identifying the Catholic vision of authentic development and the ways in which the then current economic and political climate thwarted such development for those in developing nations and particularly the poorest of individuals within them. Paul VI places emphasis on the primacy of solidarity and charity among Christian virtues while emphasizing the ministry of Christ regarding the least well off in society.

influence of Marxist ideology and globalization and industrialization's effect on the asymmetric development of the global North and South, the conference resolved that the poor or oppressed were those to whom the Church, in the spirit of Jesus' ministry, had a primary obligation to love and serve:

The Lord's distinct commandment to "evangelize the poor" ought to bring us to a distribution of resources and apostolic personnel that effectively gives preference to the poorest and most needy sectors and to those segregated for any cause whatsoever, animating and accelerating the initiatives and studies that or already being made with that goal in mind.⁶⁷

To effectively act in solidarity with the poor, the Bishops suggested the creation or modification of social institutions that would directly combat the injustices and oppression experienced by the poor. As it has been made clear in earlier chapters, it would be a mistake to equate the condition of Third Agers *as such*; however, the proposed communal responses to the needs of the poor share a similar spirit with the proposal for Third Agers. As the interpretation of preferential option for the poor has expanded to include other marginalized groups, such as “the those without health care and...those without hope of a better future,”⁶⁸ Third Agers have been made subjects of the principle. Third Agers who are most in need or most oppressed would require immediate attention, i.e. the unemployed, homeless, chronically ill, and impoverished, with the needs of other Third Agers being met in due time with responses proportionate to their needs. As was indicated in chapter two, Third Agers of color experience a lower life expectancy than their white counterparts,⁶⁹ and are more susceptible to certain health conditions later in life. When this

⁶⁷ Conference of Latin American Bishops. 1968. *Poverty of the Church*. §9.

⁶⁸ *Sollicitudo Rei Socialis*. §42.

⁶⁹ The CDC reports the following statistics for life expectancy at birth for persons born in 1950: White Men, 66.5; White Women, 72.2; African-American Men, 59.1 African-American Women, 62.9; Hispanic Men, Hispanic

reality is compounded with a preexisting economic disadvantage from underemployment or wage inequality, Third Age women of color experience life after full-time work quite differently than men. Women are more likely to be forced out of work through ageist practices and policies, but that discrimination is only magnified when they find themselves unable to obtain work before Social Security eligibility or, more generally, when the realities of financial insecurity in retirement materialize.⁷⁰ For a majority of Americans who have been unable to save for retirement or for the type of retirement lifestyle they are sold through advertising, living the good life becomes increasingly difficult. Living as a member of any one of these demographic categories comes with a series of avoidable or at least potentially avoidable obstacles to aging well; being a Third Age woman of color makes living the good life in aging seem near impossible. The vulnerability of the above-mentioned woman suggests further reason for the preferential option for the aging to be reaffirmed across the socio-political landscape. It is in this sense that a preferential option for the aging, which in some cases will be the poor, is necessary so as to ensure Third Agers opportunities to participate, contribute, and flourish.

Women. Once the individuals reach age 65, their estimate life expectancy increases by approximately 13 years across all four groups. Accessed February 23, 2017. <https://www.cdc.gov/nchs/data/abus/2015/015.pdf>.

⁷⁰ The Department of Labor reported that in 2015, men aged 35-44 had a workforce participation rate of 90.4%, and men aged 45-54 85.9%, and 55-64, 69.8%. For the same year, women aged 35-44 had a workforce participation rate of 74.3%, 45-54 73.4%, and for 55-64-year-olds a rate of 58.5%. In 1980, the participation rates for the same groups of women were: 65.5%, 59.9%, and 41.3% respectively. For today's female Third Agers, their participation rate in their 30s and 40s shows that less than 70% of women had the opportunity to begin planning for retirement, assuming that was a possibility given their other expenses. In 1998, the rates for the same groups of women were: 77.1%, 76.2%, 51.2% respectively. In their 40s and 50s, the data reflects an uptick in participation that can help women plan for retirement, but the truncated duration of life-time work as they enter their 50s and later 60s does not necessarily offset preciously missed opportunities for financial success. Participation rates have improved, and future generations of Third Age women will likely be more financially secure, but the situation of Third Age women of color still lags behind. The Bureau of Labor and Statistics reports that in 2015 full-time wage and salary working women earned 81% of what their male counterparts earned. The statistic was first recorded in 1979 when women earned 62.3% of what men earned. Full-time working African-American and Hispanic women had a median weekly earning of \$615 and \$566 compared to white women who earned \$743. Accessed February 23, 2017. https://www.dol.gov/wb/stats/latest_annual_data.htm#labor; <https://www.bls.gov/mlr/1999/12/art1full.pdf>; <https://www.bls.gov/opub/reports/womens-earnings/2015/home.htm>.

Preferential treatment, however, does not infer deferential treatment, and it does not exempt Third Agers, in proportion to their capabilities, from their obligations to others. As the dissertation has repeatedly shown, aging is not uniformly experienced and Third Agers are not homogenous regarding needs and capabilities. With this in mind it is necessary to call attention to the notion of intergenerational justice and its role in an ethics of aging. While Third Agers will benefit from the social situation created by the principled framework of CST vis-à-vis their ability to pursue the good life, they are also obliged to contribute to the good life of others. A nascent vision of intergenerational justice appears in the *Compendium* concerning protection of the environment in the form of intergenerational solidarity.⁷¹ It has been invoked by Pope Benedict XVI⁷² in a way that demonstrates the connection between the environment and issues of economic and political justice, and most recently by Pope Francis,⁷³ who also connects ecological sustainability to the authentic human development.⁷⁴ Despite its significance, only focusing on the environment would be a mistake given the ethical implications of intergenerational solidarity regarding the Third Age.

Intergenerational solidarity obliges Third Agers to pursue their own vision of the good life in view of their younger peers. Just as an aging person would not want to be neglected in the work place or at a hospital because of a more valuable younger person, so too the younger person

⁷¹ *Compendium*, §470. “From a moral perspective based on equity and intergenerational solidarity, it will also be necessary to continue, through the contribution of the scientific community, to identify new sources of energy, develop alternative sources and increase the security levels of nuclear energy.”

⁷² Benedict XVI. 2009. *Caritas in Veritate*, §48

⁷³ Francis I. 2015. *Laudato Si'*, §159-162.

⁷⁴ Stewardship is a theme of many writings within the Catholic Social tradition, however it is not referenced as a principle within the *Compendium of the Social Doctrine of the Church*, thus it is left out of the discussion. Still, it has a place within the discussion of intergenerational justice and solidarity, and will continue to do so as the good life in aging is considered more specifically in view of ecological concerns.

cannot be treated unfairly on account of the aging person's needs. Intergenerational solidarity compels Third Agers to curtail any behaviors fueled by individualist and consumeristic tendencies that have detrimental effects on younger generations. The range of those effects is broad, and it is unfair to suggest that all Third Agers consume so wastefully, but for those who do, it is important that they are compelled to scale back on the use of unnecessary medical resources, that they actively participate in the greening of American society (this is especially true of those who can afford to do so), and that they generally be more financially responsible in the event of unsettled debt being passed down to their children. Third Agers are not entitled to thwart the participation of others because of their own experiences of being marginalized in selected ways.

Though determining the limits of medical resource consumption echoes the debate between Callahan (aging as natural) and Caplan (aging as disease), a principle of intergenerational solidarity can help negotiate the middle ground between the two insofar as the principle would not trump the aforementioned principle of solidarity within an ethics of aging and it would be based upon an individual's capabilities, thus allowing the Third Ager the freedom to live the good life in aging that he or she envisioned. Instead of considering Callahan's call to forgo treatments because of one's mortality and the needs of others, intergenerational solidarity obliges individuals not to be wasteful of medical resources, and to use only what is medically necessary or that which will improve or maintain a medically-defined state of wellbeing. Intergenerational solidarity challenges the likes of Caplan and others who suggest that the disease of aging be overcome and life be radically extended despite its cost to the individual and the health care system. Determining the particular limitations will require

discussions with Third Agers, medical professionals, lawmakers, ethicists, financial planners/managers, and insurers to name a few.

Furthermore, intergenerational solidarity obliges Third Agers to be held accountable to future generations beyond their use of medical resources. The social welfare programs to which Third Agers are entitled, Social Security and Medicare, are not always needed by the recipient. For the privileged portion of Third Agers, the same ones who have the discretionary income for cosmetic procedures and continued consumeristic behaviors, their Social Security distributions and structure of premiums, copays, and coinsurances within Medicare must be adjusted. Reducing or eliminating the amount of Social Security funds distributed to individuals seems unfair on the surface, but for the well-to-do retiree, that support is superfluous in light of personal savings (pensions, retirement funds, etc.). The leftover funds could be used to support other marginalized groups in line with a solidaric vision of community life, or could be reallocated to other Third Agers whose Social Security benefits are inadequate. Redistributing sacrificed benefits to peers is a form of intragenerational solidarity that can directly benefit their peers who are underinsured by Medicare. Given that most Third Agers who are eligible for Medicare (Parts A and B) will find it necessary to purchase additional coverages offered under Part C, restructuring Medicare such that Part C is a subsidized option outside of the Parts A and B for affluent Third Agers would generate a surplus to be used to improve the coverage options in Parts A and B.⁷⁵ program. Such a strategy would enable the majority of Third Agers access to the type of comprehensive care they need without financial worry. Of course, there remains the

⁷⁵ The individual could purchase Part C without having to enroll in A and B. C would be federally subsidized so that the cost of Part C is less than traditional private insurance in fairness to the individual who has paid into SSA throughout his or her life, but it would not require the affluent Third Ager to withdraw from the funds allocated to Parts A and B.

option that the most affluent Third Agers abstain from Medicare entirely, an option that inter- and intragenerational solidarity oblige such Third Agers to consider. Like the approaches to health care delivery above, these social welfare policies need to be considered further in consultation with a diverse group of Third Agers, policymakers, and taxpayers. Whatever form these hypothetical conversations may take, it is necessary that intergenerational solidarity be more firmly established as a principle unto itself. A right to special treatment does not mean that aging persons become the only subjects of justice. Obligations to others do not disappear once Third Agers have been given adequate opportunities to age well.

Understanding the principles of CST as obligations that all persons have toward each other, albeit in different ways, explained by the distinction among different kinds of obligations, requires the acceptance of Catholic anthropology's two basic components: dignity and sociality. As duties that produce a more just environment for the aging person's pursuit of the good life, the principles of CST promote the virtuous practices of communal living while protecting individual autonomy in regard to individualized visions of the good life. Introducing the principles into the organizations and institutions that mediate an aging person's experience of the good life, from a community center to a federal health organization, is required for an ethics of aging. The principles, when embraced by individuals and social institutions, will impute responsibility upon all persons in working collectively to enable aging persons to pursue the good life autonomously, with dignity, and with the knowledge that they can rely upon others whenever achieving the good life is inhibited.

Conclusion

The obligations born of the principles of CST provide the normative framework for aging

well. Solidarity, subsidiarity, participation, and the preferential option for the marginalized, along with a distinct principle of intergenerational solidarity or justice oblige institutions and individuals to provide and care for aging persons in such a way that their dignity is honored and autonomy protected. The dignified life described by Martha Nussbaum is helpful in articulating what conditions are integral to one's flourishing, and the principles of CST incorporate much of what she outlines in a way that preserves the Third Agent's agency. The capabilities are freedoms, so the perceived threat to the autonomy of the aging person is mitigated, and in fact, the agent's autonomy is protected rather comprehensively given CA's broad scope. When brought into the fold of principles as part of CST's understanding of dignity, the autonomous Third Ager is enabled to live the good life, but CST goes beyond the simple adoption of CA.

As a framework for an ethics of aging, the principles of CST are able to articulate the conditions of dependency and interdependency not simply as anthropological characteristics. Instead, CST interprets dependency as an "obligating feature of personhood," precisely because it imposes duties upon others. The very concept of obligation, however must be further differentiated. O'Neill's approach does exactly this and therefore sheds light on the relationship between obligations, rights, and virtues. Solidarity obliges institutions and individuals to respond to those features of personhood, which in view of MacIntyre's continuum of dependency is particularly important regarding Third Agers whose (potential) needs may vary both in terms of timing and degree. Because the principled framework of CST does not attempt to universalize rules for all possible situations or disregard the import of virtues in contributing to the overall success of the promotion of the good, the specific dispositions cultivated in MacIntyrean and Christian communities in response to dependency are fortified in the larger pluralistic society.

Those same communitarian virtues that are oft-criticized for being too specific are given the space in which they can be tried and tested with the safety net of a larger support organization in the principle of subsidiarity. Aging well requires close attention to the needs of Third Agers, and that is simply not possible by large and distant government organizations even though the political and financial support of such institutions is necessary. Close attention to the needs of Third Agers can only be paid in local communities, which makes the principle of subsidiarity integral in the success of an ethics of aging well. Subsidiarity encourages solidarity insofar as it brings together different levels of institutions (i.e. federal-state, region-state, state-county, county-town) and forces local agencies to involve themselves more directly in the lives of Third Agers and address the specific needs of their constituents. While reinforcing the principle of solidarity, subsidiarity functions similarly regarding the preferential option for the poor and marginalized. Concern for the dignity of the Third Agers is obliged by the option for the marginalized, and adjudicated by subsidiarity. Distributions of financial, health, housing, and other forms of support from the state are necessary for aging well, but fulfilling the needs of individuals is more effectively achieved through more personal relationships. The CST framework cultivates a more just environment in which Third Agers can pursue the good life. Given its conspicuous absence from the *Compendium*, a Catholic vision of justice still needs to be considered so that the manner in which the particular issues raised by solidarity in health care, subsidiarity in the community, and the preferential option for the poor can be measured, corrected when substandard, and practiced. The question of justice that has repeatedly surfaced in this chapter raises serious questions for the Church and Catholic ethicists; to these I will turn in the conclusion.

LOOKING AHEAD

TOWARDS AN ETHICS OF AGING

The five preceding chapters have explored the concept of Third Age – a concept recently developed in gerontology modeled after Erik Erikson’s life stages. The context in which today’s Third Agers find themselves asking, ‘how am I to live well,’ revealed several imageries presented to Third Agers that claim to answer that question, and final chapter proposed a normative social ethics of aging. It was necessary at the outset to make the distinction between the person living in the Third Age and the so-called elderly or old-old person. Early on, the Third Age, as defined by Bernice Neugarten, was shown to be a rather recent development in gerontology – a point that was further supported in the discussion of the social construction of aging and ageism. In the last few decades there has been an increase in the number of individuals living contemporaneously in the Third Age; today, this demographic is primarily comprised of the Baby Boomers (i.e., those born between 1946 and 1962). While it is true that we are all aging, the ethical issues presented by this *new* Third Age are unique in that they are not traditional end-of-life questions taken up by medicine and medical ethicists. Instead, when the Third Age is distinguished from end-of-life care, medicine demonstrates the relationship between good life and health, and medical ethics reveals how we are to both make sense of and decide what medical treatments facilitate the good life. According to medicine, to live well minimally means to maintain an adequate level of physical and mental health to function. Medical ethicists go beyond their clinical counterparts and consider two prominent narratives within medical

ethics are: aging as a disease to be cured, and aging as a natural part of life. The former is problematic for three reasons: the very definition of health can shift with technological advancement such that the line between pathogenic condition and ‘natural’ will continue to be blurred; treating aging as a pathogenic process perpetuates a cultural fear of mortality that contributes to and is fueled by the technological imperative at work in modern medicine; and, radically extending life will bring with it further questions of equitable access, distribution, and quality of life that already strain our health care system. ‘Aging as natural,’ while better than its extreme alternative because it allays the fear of aging as inherently diseased and promotes a generally more positive outlook, can sometimes be interpreted as a defeatist position that would have Third Agers compromise on any and all medical care in light of our inevitable end. Navigating the space between these two poles remains the task of health care ethicists moving forward, but at present, it is the Third Ager who is in the proverbial driver’s seat in deciphering how to live well in light of these narratives.

The task of living well in the Third Age is done in the context of American consumer culture which not only shapes images of the good life, but also images of the Third Age/rs. A profound value placed on independence as essential to the good life is mediated through American history, notably through the development of a capitalistic economy. Individual autonomy and contributing to the economy as a laborer are markers of American self-identity that, when weakened in the Third Age, can cause potential crises. In response to the search for a *new* self-identity, consumer culture urges Third Agers (as it does everyone else) to consume specific products to feel better, to live well. However, consumer culture has a powerful ally to target the vulnerable Third Ager, medicine and medical ethics. Anti-aging medicine, cosmetics, and cosmeceuticals fit the narrative that aging is a disease. Cosmetics and cosmeceuticals have a

dual purpose: they perpetuate the idea that looking younger causes one to feel better and therefore live well; and, they function in some cases to enable individuals to remain in the workforce because looking younger is believed to mitigate ageist stereotypes. Undergirding the perceived need to keep working is a cultural emphasis on being productive – if one is not contributing to society, then one has limited social value. Ageist practices are not limited to the workplace, though their impact there has a ripple effect on at least a Third Ager's future health care and housing needs, both of which may inhibit the American vision of living independently.

Responding to what first appeared to be a question of health care ethics required a broader exploration of theological and philosophical frameworks. The theological responses to the question of aging well were of three types: community ethics, spiritual ethics, and virtues ethics. A community-centric response emerges from the biblical tradition: persons who had survived into their 60s were believed to have earned God's favor, and in turn were to be respected by the community and teach the [religious] tradition to younger persons. Modern spiritual responses place questions of aging in context of the eschatological promise: Third Agers should remain faithful and hopeful, continue to be loving toward their neighbors, and remember that life on earth is only part of God's vision for humanity. Virtues ethics approaches to aging well draw on both the community and spiritual responses, but move beyond the theological virtues alone. The contributions from virtues ethics identify specific practices relevant to the experiences of Third Agers necessary in cultivating the right character for living the good life. Proposing individual practices raises questions, however, because of the ease with which such suggestions can be viewed as another individual-centric response shaped by an individual-centric culture. Turning to the individual as the one who can live well so long as he or she does x, y, and z, ironically undermines the historically important community influence present in the

theological tradition. Implicit in the theological responses is the acceptance of sociality as a fundamental condition of human nature; that living together, not in isolation, is key in living the good life. Because of the ways in which ‘autonomy as independence’ reveals itself in many of the obstacles facing Third Agers, the significance of sociality was explored so as to begin the work of constructing an ethics of aging. As a basic human characteristic, sociality revealed that humans are not only social, but always, albeit to different degrees, dependent upon others.

Within the community setting, the Third Ager is confronted with the truth that he or she has been molded by others, that all along his or her life has been lived interdependently. The Third Age is not to retreat from that reality; instead it is the time embrace it more fully. That is not to say, however, that the Third Ager resign him or herself to living in a particular community and wait to be cared for – accepting one’s dependency must be reinterpreted so as not to be reduced to only being the recipient of care. From the communitarian approach, we see that dependency does not threaten autonomy, and that living interdependently facilitates rather than thwarts individual flourishing. To ensure that this takeaway is highlighted and enhanced, the Capabilities Approach was used to develop a vision of flourishing and further preserve the importance of autonomy as the freedom of self-determination vis-à-vis the good life. Interpreting Martha Nussbaum’s central capabilities for Third Agers revealed essential conditions that would enable an aging person to live the good life. Undermining the central capabilities threatens the autonomy of Third Agers; dis-enabling them from pursuing the good life is an offense to their dignity. However, pointing to an injustice is not the same as correcting an injustice, and therein lies a primary shortcoming of the Capabilities Approach as a comprehensive ethics of aging. Beyond the state, which as an Aristotelian Nussbaum views charitably, the Capabilities Approach does not oblige individuals or social institutions to secure the list of capabilities, or explain how the capabilities are to be

secured other than through ‘the state.’ A similar problem is found in the communitarian responses, theological or philosophical: they are merely communitarian in that they do not cross over to the social or political sphere (institutions and structures that organize and mediate individual experience); they are limited in their efficacy for *all* Third Agers. Because both the virtues-communitarian and capabilities approaches are helpful but insufficient, we turned to a normative proposal that can identify the obligatory individual and social responsibilities that secure the space in which the good life in the Third Age can be pursued. The proposed social-ethical normative framework, informed by Onora O’Neill’s interpretation of principle as duty or obligation, outlines the requisite obligations for individuals and institutions; that framework is Catholic Social Teaching (CST) reinterpreted for the Third Age. The reinterpreted principles of CST are the basis for an ethics of aging, providing a starting point for a continued exploration because it provides a framework for reinterpreting CA in light of obligations and social institutions, and ensuring that the import of the virtues-communitarian contribution is not lost. However, CST presents its own problem that must be addressed as an ethics of aging is further developed. That problem is CST’s underdeveloped theory of justice and its inefficacy in light of the particular questions facing Third Agers today.

The normative approach to an ethics of aging well outlined in chapter five establishes a groundwork for how current institutional and interpersonal problems that thwart the good life of Third Agers can be identified and/or mitigated. A *solidaric* approach to health care delivery can ensure that Third Agers in need of medical care in order to maintain adequate levels of wellbeing will receive such care. An obligation to practice *subsidiarity* encourages more fruitful exchanges between members of the community and the larger social institutions responsible for the flourishing of those persons and communities. The *option for the poor and marginalized* compels

all members of society and its institutions to seek out those most in need; those whose plight in the Third Age is not reducible to one personal or institutional misstep, and thus require systematic responses. *Participation* obliges communities to engage with Third Agers who might otherwise be isolated; it demands that employers break free from the ageist dispositions they might hold and embrace the fact that Third Agers are beneficial to the right kind of work place. When acted upon as obligations, the principles not only secure the minimum conditions of a dignified life outlined in CA, but they also reinforce autonomy and sociality as obligating features of personhood.

The principles offer a framework in which dignity can be viewed beyond traditional Catholic descriptions (i.e. *Imago Dei*). Similarly, the normative principles assist in the realization of the *common good* insofar as this is understood as an indivisible shared commitment to unity to reach their fulfillment or to flourish.¹ Together, the principles for an ethics of aging address the issues created by a culture that is sometimes ageist, averse to dependency, and consumed by materialism; however, they are but one small part of the larger process of creating a more just society. In modern ethics, the principle of dignity and the principle of the common good are interpreted through the liberal tradition, which, in the US, has been informed by a narrow understanding of autonomy as the freedom of choice. This reductionist interpretation of autonomy posits freedom of choice as the only essential quality of the good life; the choices are made in the context of consumer culture. Within the liberal tradition, a representative definition of the common good is as follows: “general conditions that are in an appropriate sense equally to

¹ Catholic Church. Pontifical Council for Justice and Peace. 2004. *Compendium of the Social Doctrine of the Catholic Church*. Vatican City; Washington, DC: Libreria Editrice Vaticana. §164.

everyone's advantage."² Interpreted through the liberal tradition, the common good presented by John Rawls does not attend to the inequalities allowed by Rawls's own framework; instead, the common good to be pursued is the collection of goods to be distributed that generally benefits the greatest number of individuals. Presenting the common good in this way runs counter to the Catholic vision of the common good; however, a well-developed response to this interpretation is lacking. More strikingly, the Catholic social ethical tradition does not provide the theoretical reflection of the relationship between the common good and contemporary theories of justice, and a framework that could be directly used for an ethics of aging. For example, there is no principle of justice found alongside the other principles in the *Compendium of the Social Doctrine of the Church*. In what will follow, I will briefly outline the direction of the theological tradition could be used to begin addressing this question.

Drawing upon the relevance of justice in the particular questions emerging in health care ethics, I identified *intergenerational justice* as an additional principle for an ethics of aging. This was necessary because without attention to members of other age groups and future generations, it would be impossible to say that an ethics of aging accomplishes more than establishing 'fairness' or 'equality' among Third Agers alone. Intergenerational justice names the obligation Third Agers have toward others, a question that is particularly relevant in terms of ecological impact and health care resource allocation, and necessary for an overall concept of a more just society. The place of justice in an ethics of aging will need to be explored further, specifically in regards to the health care, economic and social policies, and their interrelation with the medical and cultural imageries presented in Chapters One and Two. Though Pope Francis and several of

² Rawls, John *A Theory of Justice, Revised Edition*. (Cambridge, MA: Belknap Press: Harvard university Press, 1999), 217.

his predecessors invoke the language of intergenerational justice, the tradition relies upon an implicit rather than explicit theory of justice. The *Compendium* considers justice not as a principle but as a “fundamental social value.”³ As a value, justice serves as a point of “reference for the proper structure and ordered leading of life in society,” but, because of the autonomy of the public sphere and its institutions, the Pontifical Council for Justice and Peace (PCJP) does not attempt to offer specific commentary on how justice might be achieved.⁴ Yet, in its explanation of the elements of justice, albeit brief, commutative, distributive, and social justice are identified as integral to the Church’s vision of justice. Within the *Compendium*, these elements receive no extended treatment, and in fact, no substantive definition; instead, they only refer to previous Church documents in which they have been invoked, primarily the *Catechism*, and the Papal encyclicals *Laborem Exercens* and *Sollicitudo Rei Socialis*. In John Paul II’s encyclical letters, justice is connected to peace insofar as the conflicts of the 20th century could be traced to the disparities between the wealthy and the poor. Linking justice to peace, and particularly poverty and the distribution of wealth, John Paul II turned to commutative and distributive justice as appropriate responses to the injustices that contributed to the violence of the 20th century. Commutative justice addresses the question of fairness in exchanges or agreements between two individuals or private social groups. Distributive justice “requires that the allocation of income, wealth, and power in society be evaluated in light of its effects on

³ Pontifical Council for Justice and Peace, *Compendium*, §197.

⁴ Pontifical Council for Justice and Peace, *Compendium*, §197. The Church maintains that its limited knowledge of the technical workings of political and economic systems, for example, precludes it from offering specific solutions to problems in those areas. Instead, the Church can only highlight what it believes to be problematic and call upon others to resolve the problem(s). The other half of this posture is shaped by the Church’s claim that it cannot inject itself into matters that are not under its political purview; autonomous nation-states, for example, are tasked with governing, not the Church.

persons whose basic material needs are unmet,”⁵ and that that injustice be adjudicated by the political powers responsible for promoting the good of the individual or the community. Social justice, however, is much more abstract than either commutative or distributive justice.

Described as the total vision of justice, social justice implies that “persons have an obligation to be active and productive participants in the life of society and that society has a duty to enable them to participate in this way,”⁶ and thus is also referred to as contributive justice. The descriptions do not identify a particular aim of justice; instead that aim is often uncovered in conjunction with the principles of CST – justice is achieved when the principles are fulfilled. However, justice should be the idea that guides those principles, measures their efficacy, and demands their improvement over time. Applying the tradition of CST to the question of the good life in the Third Age, it has become clear that the principles may well serve as a starting point but require further development of a normative ethics that complements a virtues ethics approach. Yet, in light of the limited account of a principle of justice within this framework, the social ethics tradition of the Church must be revisited. For example, even the extensive theory of justice of Thomas Aquinas is not taken up in the *Compendium* or the encyclicals.

Although it cannot be the purpose here to systematically account for Aquinas’s treatment of justice is not the purpose here, it is important to note that he explains commutative, distributive, and a nascent concept of social justice, with greater detail than the *Compendium*. Commutative justice is described with the Aristotelian term ‘arithmetic mean’ that refers to the quantity of the resource (i.e. money or property) that is owed to the individual. Borrowing from Aristotle again, distributive justice is explained as a ‘geometric’ mean, in which the importance

⁵ United States Conference of Catholic Bishops. 1986. *Economic Justice for All*. §70.

⁶ USCCB, *Economic Justice for All*, §71.

of the good to be distributed is considered and rendered proportionately. Restitution presumes an unjust exchange that must be rectified. Rectification fits into Aquinas's account of general or legal justice that emphasizes the importance of interpersonal relationships within society insofar as laws are directed toward the good of individuals vis-à-vis the common good of all persons.⁷ Additionally, legal justice is presented as an obligation⁸ that is to be satisfied equally. These brief comments are only meant to allude to the fact that the understanding of justice can be retrieved from the theological tradition and serve as a starting point for a more robust principle or theory of justice within the tradition of CST.

The treatment of justice in Aquinas is limited, however, as has many scholars have noted. For example, as Jean Porter remarks, "the norm of distributive justice is set by reference to whatever is the organizing principle of the community in question," and that "he [Aquinas] has little to say about the norms of distributive justice *per se*."⁹ Aquinas may be more descriptive of the role of distributive justice as a means to an end in an organized state than the *Compendium*, but the good to be distributed and their importance in the good life is similarly inadequate. Trying to implement a system of equality in political institutions complicates how effective turning to Aquinas can actually be in nuancing a social ethical notion of justice.

The good of the individual and the common good feature prominently in Aquinas's discussion of justice. An Aristotelian notion in *Politics*, the common good is the idea that the collective welfare of all individuals in society can be promoted and protected through

⁷ Jean Porter. "The Virtue of Justice (IIa IIae, qq. 58-122)" in *The Ethics of Aquinas*, ed. Stephen Pope (Washington: Georgetown University Press, 2002), 273.

⁸ *Summa Theologiae*, IIa IIae, q80, a.1.

⁹ Porter, "The Virtue of Justice," 278.

citizenship, which is directed by a formal government and legal system. Determining exactly what the common good is, in part because of its historical development from *eudaimonia*, is difficult; using it as a legislative guide is impossible. Aquinas follows in this tradition linking justice to the good and the common good, elaborating upon it further than Aristotle did, as Porter notes.¹⁰ According to Aquinas, the individual's just acts contribute both to their individual good and to the common good, resulting eventually in a more just state. Charles Curran notes, "the common good ultimately flows back to the good of the individual and thus brings together the good of the community and the good of the individual."¹¹ In pluralistic societies and modern theories associated with them, however, the *common* notion of the common good is interpreted in light of contract theories of justice: those goods that societies agree upon as beneficial are to be exchanged in the market and/or distributed by the state. Because of its connection to the common good and the ways in which the Church has defined it,¹² the concept of social justice raises particular problems.

A number of theologians and ethicists have noted the ambiguity of social justice. Lisa Cahill acknowledges that social justice is never precisely defined, but comments that it generally is an integrative concept that brings together the questions of interdependence, interpersonal

¹⁰ Porter, "The Virtue of Justice," 272. "Aquinas's own theory of justice as developed in the *Summa theologiae* draws on all of these [Church fathers, Aristotle, Cicero, and others] conceptions. What is distinctive about his theory is the way in which he integrates them into a systematic account. In the course of developing this account, he analyzes and coordinates the different perspectives on justice, as a general virtue, as one particular virtue among others, as the virtue preeminently concerned with right relations among people, and as an integral component of the Christian life."

¹¹ Curran, Charles E. *Catholic Social Teaching: A historical theological and ethical analysis*. (Washington: Georgetown University Press, 2002), 145.

¹² Formal definitions of the common good appear in *Mater et magistra* §65: "the sum total of those conditions of social living, whereby human beings are enabled more fully and more readily to achieve their own perfection;" and *Gaudium et spes* §74: "the sum of those conditions of social life by which individuals, families, and groups can achieve their own fulfillment in a relatively thorough and ready way."

relationships, and social institutions.¹³ She further remarks that social justice consists of what all persons contribute to the common good through their active participation in society. Thomas Massaro concludes that all definitions generally “boil down to the goal of achieving a right ordering of society,” which will “ensure that all people have fair and equitable opportunities to live decent lives free of inordinate burdens and deprivations.”¹⁴ Important as the concept of social justice is, its status as an element of justice within the PCJP’s treatment of the subject raises more questions than it answers, and it becomes increasingly clear that the current Church position on justice needs revision. Without clarifying the relationship between social justice and the common good, it will remain difficult to translate the Catholic vision of justice into the sphere of political ethics, and more specifically, the health care policies that are a concern of this dissertation.

A reimagined Catholic social ethical concept of justice is desperately needed to address the problems within the health care system and medical ethics presented to Third Agers. On the one hand, a systematic Catholic social ethical treatment of justice will be able to respond to the ethical challenges presented by the absolutization of autonomy in medicine (i.e. a Third Ager’s wish for life extension technology or request for elective cosmetic surgeries in the face of other needs), while on the other hand, justice will serve to check on and ensure that the solidaric vision of the health care system in its endeavor to improve the wellbeing of all persons beyond clinical care settings is practiced. To that end, justice will ensure that the successful practice of principles of CST identified as necessary for an ethics of aging are not sabotaged by health-related

¹³ Cahill, Lisa. *Theological Bioethics: Participation, justice, change*. (Washington: Georgetown University Pres, 2005), 47.

¹⁴ Massaro, Thomas. *Living Justice: Catholic social teaching in action*. (Lanham, Maryland: Rowman and Littlefield, 2008), 1.

problems. Regarding the economic and social policies that directly impact Third Agers, a Catholic social ethical concept of justice will not only ensure that the marginalized and oppressed are enabled to live well, but it will also advocate for the reorganization of institutions. Here, the critique raised within political philosophy, namely that justice cannot exclusively be defined using the distributive paradigm, must be taken seriously. I have argued that, in particular, the concept of intergenerational justice must be further developed: it will ensure that the policies put forth are aligned with the interests of Third Agers on the one hand, but that their interests do not supersede those of other members of society. Overall, justice must aim to secure the necessary environment in which Third Agers can pursue their notions of the good life, and assure that they can depend upon others while acknowledging that their own needs and freedoms must be balanced against the needs of others. Further developing a Catholic social ethical notion of justice is necessary in providing guidance for adjudicating the dilemmas that arise when subsidiaric community participation initiatives are complicated or stymied, when solidaric health care delivery options are confronted by competing interests and values, or when Third Agers are denied opportunities to work or are otherwise discriminated against. It is not only necessary but also possible, this dissertation has argued, to offer an ethics of the good life of and for the Third Age from within the tradition of Christian ethics. If the normative approach of CST modeled here were adopted and further developed in light of the shortcomings concerning the theory of justice, Catholic ethicists would be better positioned to respond to the ethical questions that continued to be raised in health care and elsewhere in the Third Age.

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During his tenure at Loyola University Chicago, Cintron served as a research assistant and teaching assistant for several faculty members. In 2014, he relocated to Connecticut after marrying his wife in May of that year.

Throughout his time in Connecticut, he has worked as an adjunct instructor. His courses have included: introduction to religious studies, contemporary moral problems, Catholic social ethics, and bioethics.

The dissertation reflects Dr. Cintron's interest in the tension between the theoretical approaches to and applied dimensions of biomedical ethics.