

Several months ago, I shared with Rev. Hilary a small essay I had written about Aging on Acceptable Terms. It was motivated in part by a marvelous book entitled *Being Mortal* that I shall discuss later, but mostly by observing my wife's decline. Rev. Hilary thought that this was an important message for the congregation and that I should present it. Since it was already written, I said sure. But that was before my wife died. Now I'm not so sure. So if I break up, please stay with me.

Aging isn't all that bad. In fact, the period right after retirement is wonderful. You get senior discounts at many stores and the Department of Motor Vehicles lets you move to the front of the line. We all image that aging is simply getting older, having free time, traveling, retaining our health, bouncing children on our knees and going to bed one night and, unexpectedly, not waking up. The Catholics call this a "good death." But that is a wish; it is not a plan.

Unfortunately, evolution has it's own plan for us. It keeps us reasonably healthy until we pass our genes to the next generation and then for many it's downhill all the way. As the Peanuts cartoonist Charles Schulz said, "Just remember, once you're over the hill you begin to gain speed."

My remarks today are about the need to plan for that downhill acceleration and ultimate crash. Aging brings many changes. While you can't anticipate all of them, you can confront some possibilities early and agree on what kind of outcomes you are willing to accept.

I had a dear friend named Tom Kelly who worked with me at Bell Telephone Labs. He developed Parkinson's disease and suffered terribly for over five years. He could not walk and had tubes all over his body for breathing, feeding and medication. He could not even recognize his wife or children. When it came time to pull the plug, his wife and doctor thought it was the compassionate thing to do. But one daughter objected because of her Catholic belief that only God could give and take life, and she, personally, did not want to be damned for taking his life. So Tom suffered for another two years at great pain and expense. This

could have been avoided if only there has been some discussion and understanding of Tom's wishes with his children.

So the first lesson is this. Once you have come to some conclusion about how you are willing – or not willing – to age, it is all-important to inform your relatives, friends, and especially your doctors of your preferences so there is no question when a decision is needed.

The first part of the plan is deciding where you want to live in old age. And this should be done now when you are healthy. Many say they want to stay in their homes. Others say they want to move to Florida or Arizona where the weather is good and the taxes are low. Both assume good health.

But houses anywhere can be downright unfriendly to older people. They have steps. My wife got to the point where she couldn't climb the 14 steps to our second-story bedroom, forcing a move. Older houses often have doors too narrow for a wheelchair to pass. The electrical outlets are close to the floor where use can't see them with bi-focals. Some have sunken living rooms or shag carpets or wood floors with throw rugs that can throw you. Shelves are often too high and tempt elders to use a footstool to reach things. And essentially no bathrooms are designed for people with infirmities.

For many seniors, the American dream of home ownership begins to tarnish. They become quite willing to give up paying real estate taxes, insurance, utilities, cooking, cutting grass, removing snow and doing home repairs. An increasingly popular solution is to move into a continuing care retirement center and have these services done for you. This was the best thing that Lee and I did. We sold our home and used the equity to buy a unit in the Garlands. I have found that it costs no more to live in a retirement center than it did to maintain our home.

Most of these retirement homes have four levels of accommodation. The entry level is independent living. Lee and I choose a 1500 square foot unit with two bedrooms. We had our own furniture and belongings and did what we pleased. Because I was healthy, we could be in independent

living although Lee needed nursing care that she got through in-home hospice service that I cannot praise highly enough.

As your abilities declines, you can move into the assisted living and receive custodial care with waking, washing, dressing and eating at a bit more cost.

When your health really declines, you can move into a nursing care section for medical services at a significantly increased cost. Finally, if you are unlucky and become demented, they provide a secure memory section.

Some of these retirement homes provide the peace of mind of knowing that if you run out of money, they will care for you for the rest of your life.

If your plans call for moving into a retirement home, don't put it off. Do it while you have the energy and can make new friends. Everyone I know who has moved into a retirement home says they waited too long. This includes us. Lee arrived in a wheelchair. Not good!

After housing, the next thing to plan for is health and continuing care. There is a remarkable book on this subject entitled *Being Mortal* by Dr. Atul Gawande. The author is a surgeon who presents cases of patients from his practice who encountered end-of-life decisions.

He argues that the medical profession is trained to keep a patient alive at all costs. There is no limit to the number of procedures, surgeries, chemotherapies, radiation treatments, medications, or clinical trials that they will suggest to extend life.

But extending life is not the only goal of a patient. There is the enormously important question of the quality of life. He writes: "Technological society has forgotten what scholars call the "dying role" and its importance to people as life approaches its end. People want to share memories, pass on wisdoms and keepsakes, settle relationships, establish their legacies, make peace with God, and ensure that those who are left behind will be okay. This role is among life's most important, for both the dying and those left behind. And if it is, the way we (the medical profession)

deny people this role, out of obtuseness and neglect, is cause for everlasting shame.”

The older medical model of caring essentially amounted to warehousing seniors, providing for safety and physical needs, but not serving their psychological and existential needs. This model implies that the hospital schedule is more important than any concerns of the patient. The patient is aroused on schedule, cleaned and dressed on schedule, fed on schedule, on and on though the day and, yes, wakened in the middle of the night to check vitals, again on schedule. Their concerns are for the patient’s safety and health.

Fortunately, there are newer models today and I encourage you to look for them. The newer assisted-living facilities can provide private suites with the resident’s own furniture and locks on the doors for privacy. The seniors can set their own schedules and get assistance only when they ask for it. Their activities are of their own choosing. They can have live-in pets and visitors can come at any time. Above all, they have their own kitchens and can prepare simple meals when and if they like.

The medical model looks at this with disbelief. You mean they can have knives and stoves that get hot? That’s not safe. WELL, SO WHAT !! Each of us wants our independence. Each of us wants to decide what it means to be a human. And each of us has a story to tell...a story that is not yet complete. All we ask is to be allowed to write our own endings.

Dr. Gawande agrees and advises the medical profession: “If to be human is to be limited, then the role of caring professionals and institutions – from surgeons to nursing homes – ought to be aiding people in their struggle with these limits. Sometimes we can offer a cure, sometimes only a salve, sometimes not even that. But whatever we can offer, our interventions, and the risks and the sacrifices they entail, are justified only if they serve the larger aims of a person’s life. When we forget that, the suffering we inflict can be barbaric. When we remember it, the good we do can be breathtaking.”

Next, some of us will require major medical intervention. Lee had open-heart surgery, two hip operations, had her gallbladder removed and 13 pints of water drained from her due to congestive heart failure. We need to consider what limits we will accept regarding medical intervention.

Dr. Gawande continues: “People with serious illness have priorities besides simply prolonging their lives. Surveys find that their top concerns include avoid suffering, strengthening relationships with family and friends, being mentally aware, not being a burden on others, and achieving a sense that their life is complete.”

We never know when the big “gotcha” is going to happen. But he suggests that when it does and you are confronted with a big decision you should ask four vital questions.

- (1) What is your understanding of the situation and its potential outcomes?
- (2) What are your fears and what are your hopes?
- (3) What are the trade-offs you are willing to make and not willing to make?
- (4) And what is the best course of action that will best serve this understanding?

The trade-off is simply this: Are we willing to give up valuable days now to treatment and recovery in hope of more days later? Or do we want to enjoy the days we have now, even if there are fewer of them? “At root, the concern is about what mistakes we fear most – the mistake of prolonging suffering or the mistake of shortening life.”

Dr. Gawande says that, “At least two kinds of courage are required in aging and sickness. The first is the courage to confront the reality of mortality – the courage to seek out the truth of what is to be feared and what is to be hoped for. And the second is the courage to act on the truth we find.”

This helps a patient arrive at a clear view of how he wants to live the rest of his days. One of his patients said that he would proceed with an operation if he were assured he could return to watching TV football and eating chocolate ice cream. Another wanted to be assured that he would be free of pain. Yet another wanted to live long enough to attend a child’s wedding. We all have different wishes that are thresholds for decisions.

Which brings me to the subject of dying. . Dealing with aging and health is one thing. We have alternatives, even if they are limited. But death is so final. It is the ultimate insult to our egos and all we have lived and worked for. And it is hard for people to deal with.

It is said that there are no atheists in foxholes. But I have come to question if there is much comfort from religion when one gets close to testing his belief in an afterlife.

I recall taking a flight and sitting next to a nun. As the pilot revved the engines, getting ready for takeoff, the nun grabbed the armrests and squeezed them until her knuckles turned white. I thought to myself: if there was anyone who should not be afraid of death and be ready to go to heaven and meet her Maker, it should be this nun. But not so! In that moment, I realized that the DNA urge to live is stronger than any religious belief in salvation.

Some people have had rich and fulfilling lives and should be willing to die. But they aren't. Others have had miserable lives and should look forward to death and a rewarding after-life. But they don't either. Few people yearn to die. Call it egotism, call it narcissism, call it by any name, the fear of dying is the ultimate expression of our DNA's urge to survive. We simply cannot imagine our not being here...or somewhere. Cultural myths make death more palatable, but they don't change the reality. This is a difficult truth that many avoid, deny or shroud with wishful thinking.

This brings up the issue of late stage intervention. It is reported that 50% of all Medicare costs are expended in the last six months of a person's life in a desperate effort to avoid the inevitable. Worse, 25% of all Medicare costs are spent in the last two months. This implies that patients are undergoing extreme procedures and sacrificing extensive qualities of life when time is short and death is inevitable.

Should we accept major medical intervention at an age like 90, hoping to live to be 90 and 2 months? And yes, 2-to-3 months are the kinds of life extensions that some of the therapeutic procedures promise. Why do we agree to such extreme measures.? How long do we fight the inevitable and

why can't we let go peacefully? Why do we hang on to an end not of our choosing? It is a cultural problem that needs to be addressed.

Maybe we should pull the plug on the doctors who promote such procedures and costs and the lawyers who sue the doctors if they don't.

I have been living close to Lee's death and it does focus the mind sharply. I have stared death in the face and can honestly tell you that I am not afraid of it. And neither was Lee. Lee's decline extended over the best part of a decade. When death comes after so much pain and loss to a loved one, you can actually welcome it, however bittersweet.

Both Lee and I knew that death is a small price to pay for the opportunity to live and love. We have been blessed. We were born to good parents during the depression and learned thrift. We got good educations and entered the job market after WWII when the economy was booming. We've had meaningful, productive and even exciting jobs. We've been blessed with good friends and enriched by a religion that allowed us to retain our integrity. And on top of it all, we have received tons of unearned good fortune. How can we not be grateful? How can we not say goodbye gracefully?

There was a French priest back in the 1700s named Jean Milier. He was a Catholic who was actually a closet atheist and a hero of mine. Hew wrote about death: "We should be grateful that we are all allowed an eternal sleep after the turmoil of this world which causes more trouble than pleasure to the majority."

Well, I can't speak for the majority, but I can say that an eternal sleep sounds better than what my Baptist Sunday School teacher threatened me with if I didn't behave.

In conclusion, here are a few lessons learned about aging.

First, we really need to make peace with family and friends over any issues that have been suppressed or swept under the rug while we have the ability to think and to speak. Thinking and speaking skills often fade

before death does. I am reminded on a Broadway production entitled “I Never Sang for My Father.” I encourage you not to live with the regret of failing to mend fences or telling others that you loved them and tell them often.

Second, we need to probe the deep feelings of our spouses. I have often said that each of us will take to the grave some aspect of our lives that we are not proud of and have never shared with our most intimate friends or loved ones. We need to get beneath the surface, to find the most venerable parts, and reassure our mates that they are totally acceptable and lovable.

What did my wife need to remain a whole person when her external world was collapsing around her? What did she need to feel being loved when she was beyond returning love? How could she not feel alone when she was separated from many of the things that were important to her? We need to find a path with the best chance of keeping life worthwhile to the very end.

I learned to never start a sentence with the word “you.” When you do, it will almost always be an accusatory sentence. You didn’t take your pills... You said you would take a nap... You never... You should... You don’t ever... Caregiving can tax your patience, but it is no time to play the blame game.

You need to know that aging can require significant sacrifices. These include moving from your home, downsizing your precious possessions, losing freedoms, losing privacy and losing your faculties like seeing, hearing, walking and thinking.

And aging can be very expensive. The Personal Finance section of the Daily Herald on October 11, asked the question, “Do you have \$730,000 for nursing care?” That is the average cost for 8 years of nursing home care for the average patient with dementia. And the cost isn’t covered by Medicare. The only time you have to save is now. Planning helps you forego the whimsical urges today for the essential necessities tomorrow.

I have found it very comforting to have a pet during this experience. Gloria Kinney gave me a big, black, loving cat named Jacques who has been my

constant companion for three years. Since Lee's death, I have almost loved the fur off of that cat, just like the skin horse in *The Velveteen Rabbit*.

Finally, I encourage you to create a legacy of some service to others. As Albert Pine said, "What we do for ourselves dies with us. What we do for others and the world remains and is immortal." Lee and I found that progressively building a legacy of helping others made life more precious and death more acceptable.

The best time to think through these issues is when you and your family are not under stress. That is why I beg you to start that all-important conversation. Thinking through a personal strategy for aging is fundamentally important to insure that the right decisions will be made to retain the quality of life you prefer.

And that is my sermon.

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