Caring for the elderly – a care ethics approach

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Abstract

This paper is a contribution intended to introduce the debate on the church's role and responsibility in contributing to the healthcare of the elderly in view of the reality of a growing elderly community. This paper will focus on the contribution that the church can make towards the healthcare of elderly people. The argument is presented that this contribution can be made through care ethics. Care ethics is defined as the ethics of everyday care. Its focus is on addressing ethical matters in practice.

This study outlines the reality of an increasing community of the elderly and the impact that this will have on society, and in particular, on healthcare. From research it is evident that elderly people want to be guided through this last stage of their lives. Even if there is no desire to be assisted in the ending of life, this is not a topic that should be ignored.

An argument has been presented that the church has a role to play in the healthcare of the elderly, even though, as confirmed by South African e-publication data bases, this role has not been the focus of research. The constructive role that religion, faith, spirituality and theology can play in healthcare is further highlighted. The contributions by Geybels and Van Stichel, as well as Schotsmans and Burggraeve, are used to inform the church's role in healthcare. The outcome of the research defines four pointers: (a) The core of healthcare is caring for vulnerable people.

(b) Elderly people are defined by their circumstances. (c) Relationship building between the elderly and the care-givers is through care. (d) Care is more than merely attending to the physical needs of the other.

Keywords:

care ethics, elderly, vulnerability

Opsomming

Hierdie artikel het as oogmerk die inleiding van die debat rondom die kerk se rol en verantwoordelikheid om 'n bydrae te lewer tot die gesondheidsorg van geriatriese mense in die lig van 'n ouerwordende gemeenskap. Die artikel fokus op die bydrae wat die kerk kan lewer tot die gesondheidsorg van geriatriese mense. Die argument word verder gevoer dat hierdie bydrae deur sorgetiek kan plaasvind. Sorgetiek is die etiek van elke dag se sorg. Die fokus is om etiese uitdagings in die praktyk aan te spreek.

Diè studie beklemtoon die realiteit van 'n ouerwordende gemeenskap en die impak wat dit op die gemeenskap sal hê, in besonder gesondheidsorg. Uit die navorsing is dit duidelik dat geriatriese mense deur hierdie laaste lewensfase begelei wil word. Al is daar geen begeerte vir die einde van lewe bystand nie, is dit nie 'n onderwerp wat geïgnoreer kan word nie.

Die standpunt word ingeneem dat die kerk 'n rol te speel het in die versorging van geriatriese mense, alhoewel dit nie 'n gefokusde navorsingsarea is nie. Dit word deur die Suid-Afrikaanse e-publikasie databasis bevestig. Die konstruktiewe rol wat godsdiens, geloof, spiritualiteit en teologie kan speel in die versorging van bejaardes word verder beklemtoon. Die bydraes van Geybels en Van Stichel, Schotsmans en Burggraeve word gebruik om die kerk se rol in gesondheidsorg toe te lig.

Die uitkoms van die navorsing beklemtoon vier sake: (a) Die kern van gesondheidsorg is om vir brose mense te sorg. (b) Geriatriese mense word deur hulle omstandighede gedefinieer. (c) Die verhouding tussen geriatriese mense en sorggewers is deur sorg. (d) Sorg is meer as om net na die fisiese behoeftes van mense om te sien.

Kernwoorde:

sorgetiek, geriatriese mense, broosheid

1. Introductory comments

It will come as no surprise that worldwide there is an ever-increasing growth in the numbers of elderly people. This growth is linked to improvement in healthcare and combating of diseases in general.

Naja, Makhlouf and Chebab (2017) make reference to an expected growth in the elderly population of almost 70% from the current estimated 1.4 billion people by 2030 to 2.1 billion by 2050. In 2017, the South African-based statistics set the population older than 60 years at 8.1% of the total population. In 2019 this number is at 9.0%. Statistics South Africa (2017:3) comments that the growing number of elderly people will increase social, health and financial demands. The 2019 mid-year population estimates comment that the "proportion of elderly persons aged 60 and older is increasing over time" (South African Government, 29 July 2019).

From these comments it is clear that there is a growing elderly community and this community must be cared for.

There are different reactions to the discussion about the growing elderly community in general, and healthcare needs in particular.

Economists will immediately raise the critical concern regarding whether sufficient government funding is available to support the healthcare needs of this growing elderly community, while at individual level, the concern is affordability of healthcare. Annemans (2016) reflects on this conflict between *what needs to be done* (responsibility) and *what can be done* (affordability). The challenge deepens with Schotsmans' (2012:36) two comments on the ethical dilemma that specialised technology innovations are only affordable for the rich, and that people who are really in need of care may not have access to it.

From a South African perspective, the research on elderly communities is more about their medical needs than the needs at a public health level which includes affordability of and access to healthcare. This can be confirmed by SA e-publications (African journal connection) for the period 2012-2018. Here too, the national Health Ministry is fairly quiet on the care of the elderly population.

In another corner, there is an important partner that is quite silent on elderly care, and that is the church. This is alarming, as recent statistics from the Dutch Reformed Church and the Reformed Church suggest a decline in the number of churchgoers due to lower birth rates and immigration (Agenda, 2019). The obvious interpretation is that the church is becoming a growing community of the elderly. Besides the implication raised by the demographic information, a further limitation is the dearth of church and/or theological debate on elderly care in general and healthcare in particular in South Africa. This is confirmed by the South African e-publication data base, African Journal Connection, for the period 2012-2018. For this period, only two papers could be identified referencing geriatric healthcare in general in South Africa (references to Lategan, 2017; 2018). Clearly this cannot be regarded as a complete debate on the matter.

This does not mean that there is not a growing interest in the church's role in elderly (health)care. In support of this comment, Koss, Weissman, Chow, Smith, Slack, Voytenko, Balboni and Balboni (2018) propose a training programme for clergy to deal with spiritual concerns related to the end of life. The study's results reveal not only the spiritual needs of ill patients but also the needs expressed by the clergy themselves. The clergy makes reference to needs such as medical literacy training and reviewing of counselling approaches. Balboni, Prigerson, Balboni and Maciejewski (2019) comment that religious beliefs, for example, influence end-of-life decision making and care of patients with advanced cancer. They are proposing a scale to assess religious beliefs in end-of-life medical care. Balboni and Balboni (2018) argue convincingly that health and medicine, and faith, religion, spirituality and theology cannot go without each other. Closing a growing gap between medical realities and existential experience through faith and religion can bring compassion back to care.

2. Focus of the paper

The intention of this paper is to open the debate on the church's role and responsibility in contributing to the healthcare of the elderly against the reality of a growing elderly community. The paper will focus on the contribution that the church can make towards the healthcare of elderly people in the context of an increasingly elderly population.

The contribution will be presented within the framework of care ethics. This framework will be based on Christian ethics that are vested in Biblical principles, church history, and traditions and confessions. Geybels and Van

Stichel (2018:117-118) remark that Christian ethics are based on the *following of Jesus and the realisation of the kingdom of God*. Ethical behaviour must be informed by the double command of love. They continue to argue that relationships with fellow persons make the relationship with God visible.

The research will be a literature analysis as part of a qualitative study (see paragraph 3) and the role of social determinants in public health (see paragraph 4).

3. Research methodology

Qualitative research identifies patterns in the knowledge base of a particular topic. These patterns refer to what the main themes are in a particular research field – in this case, elderly healthcare from a care ethics point of view. Silverman (2006:43) confirms the value of qualitative research as making known what was not known before. Dassen, Keuning, Jansen and Jansen (2016:53-54) add to the meaningfulness of qualitative research by stating that it is about representation. The purpose is to gain an understanding of something that is not generally known.

Within a qualitative research approach Trafford and Leshem's (2012:68-74) idea of 'literature' in research will be followed. According to them a literature and document review can be defined as "a specific body of knowledge … that is recognised by its respective users". The literature review has a "recognisable identity when someone explains its corpus". This is explained through the researcher's lexicon and paradigms (Trafford & Leshem, 2012:68).

Qualitative research will assist in addressing the research problem. The research problem is an exploratory research question (Jansen, 2008:11) and can be phrased as: *how can the church contribute to the healthcare of elderly people via a care ethics approach*?

As there is no hypothesis linked to this research problem, quantitative research is not necessary to confirm the research results.

To perform the research, it will be important to unpack the social determinants relevant to elderly healthcare. The next section will attend to this.

4. Social determinants for elderly care

Chan (2017) and Berridge (2016) confirm the significance of social determinants for healthcare. Social determinants refer to the impact that social factors can have on the health of people. From a public health perspective, food safety and security, access to healthcare and finance, accommodation and sanitation, can all impact on the life of elderly people.

Vanlaere and Gastmans' (2010) study on elderly people identifies five themes of care that are required for elderly care. These themes are dignity, interaction with the person, sexuality, end-of-life care and euthanasia/end-of-life, especially when the patient cannot make any informed decision. It is evident that no aspect of elderly care can be isolated from the person him- or herself or be removed from the person's needs.

The Constitution of the World Health Organisation (WHO) (adopted and signed in 1946, as amended) defined health as "a state of complete physical, mental and social well-being and not merely the absence of the disease or infirmity".

From the WHO's definition of good health, it is evident that it is not limited to physical needs only but also involves emotional needs and service delivery.

In response to a rapidly growing elderly society, the WHO released a report on ageing and health (2015:159-196). In this report the focus is on a redefinition of healthy aging on the basis of *capacity* and *ability*. This redefinition centres on functional ability. Functional ability includes the combination of the intrinsic capacity of the individual, relevant environmental characteristics and the interactions between the individual and these characteristics. Beard, Officer, Araujo de Carvalho, Pot, Michel, Lloyd-Sherlock, Epping-Jordan, Peeters, Mahanani, Thiyagarajan and Chatterji (2016:12) point out that the report is not so much looking at what older people do (functionalities), but rather "on building the abilities that will allow them to navigate their changing world and to themselves invent new and better ways of functioning".

In their analysis of an ageing world, Naja, Makhlouf and Chebab (2017: 4363) report that growing older means decline at cellular, organ or whole-body level with increasing levels of chronic illness, and diminished wellbeing. Ageing in general has implications for social security, economy, organisation and delivery of healthcare, caregiver availability and constraints, society and policy.

5. A Biblical perspective on healthcare for the elderly

In the Old Testament, care for people is evident through the responsibility one person has towards another person.

This responsibility is apparent through the Ten Commandments, for example, where responsibility must be taken for the other through the protection of the other's life, relations, honour and belongings. Although not explicitly stated, honouring one's parents implies direct evidence to care and respect for the elderly. Leviticus 12-15 give direct evidence precisely on how care should be taken of other people. Additionally, although the elderly is not directly mentioned, the suggestion is that the fellow person's dignity and welfare should be honoured at all stages of life. Zimmerli (1978:141-142) observes the importance of reflecting the nature of God in whatever people are doing. "Be holy, because I am Holy" (Leviticus 19:2) is a clear indication of what the basis should be of all interactions with God and fellow people.

In the New Testament elderly care is evident through the *koinonia* and *diakonia* of the early church community. Van der Watt (2014:317-318) comments on this by saying that believers' care is expressed through their connectedness to one another. In this context, love is a central feature. As a consequence, edifying and positive behaviour is expected. It follows naturally that it is a responsibility to care for other people. The care touches on most basic aspects: eating, drinking and living in peace and harmony. This calls for service towards the fellow person.

Within the gospels, especially in the Gospel of Luke, the highlight is on the poor (*ptochos*). The poor in Luke refers to more than merely those people without money. It includes those without family register, descendants, education or cultic purity. These are typically marginalised people. The irony is that these people are now on Jesus' guest list. Through this act, the borders between people are broken down and their human dignity is given back to them (Joubert, 2012:176, 179, 181-182; Luke 14 1-24).

The conclusion is that vulnerable groups must be cared for. This care is both physical and religious. Provision in daily needs cannot be freed from caring for the soul of the person. This approach relates to the body-soul dualism influenced by Greek philosophy. The principle here is to have a holistic approach when caring for people. The principle approach implies a balance of both, and not playing them off against each other. Swart (2017:122-123)

interprets this interconnectedness effectively in his comment that “Although the association between spirituality and positive health outcomes has been established, spirituality does not replace good medical care and treatment based on sound medical science.”

Within this framework, care ethics can now be presented as a partner in the church’s healthcare.

6. The contours of care ethics

Grypdonck, Vanlaere and Timmerman (2018:9) give a hands-on definition of care ethics. They say that care ethics deals with the ethics of everyday care. The focus on the ‘other’ is essential. This avoids a situation where one’s own agenda is pushed. Relations are important. It is not so much about saying something to someone as it is about ‘being there’ for a person. They emphasise this in a different way: *the person is central, not what we do*. The intention is to promote growth. It recognises the vulnerability of a person. This is a continuous process. To be there, calls for hope (Grypdonck, Vanlaere & Timmerman, 2018:69, 102, 103, 105, 134).

Tjong Tjin Tai (2014:195) supports this by commenting that care ethics is the consequence that the practice of care has for ethics as a discipline.

This concept of care ethics originates from Carol Gilligan’s book, *In a different voice* (1982). Gilligan’s care ethics is a different ‘voice’ to a fixed approach to women’s development and ethical behaviour. Ethics cannot be understood on the basis of principles only. The different voice is the role that communication, responsiveness and relationships play in dealing with ethical dilemmas. To her it is about answering *contextually* and not *categorically*. Responsibility is an extension of what people are doing to support other people and not a limitation in dealing with their needs.

An important focus of care ethics is relationship building when care is taken of other people. Vanlaere and Burggraeve (2017) articulate this well when commenting that care ethics is about relationship building.

Relationship building is further developed by Grypdonck, Vanlaere and Timmerman (2018:15) in their comment that care in reality often challenges more ethical dilemmas than those that exist on a theoretical level. Ethics dealing with the reality of the dilemma is essential to healing people. This is only possible when there is a relationship between care-giver and care-receiver. This care, however, is not limited to these two parties only. The relationship involves all who are part of this network of care giving and

care receiving. Care ethics is more than the mere application of theory and principles to ethical dilemmas in everyday life. It is essentially about restoring relationships and dealing with situations in a pragmatic manner. Experience is important when dealing with ethical dilemmas in practice. Four essential characteristics for care ethics are defined: care ethics is about care, relations, commitment to the other, and responsiveness. Care ethics focuses therefore on care-givers and care-receivers. Sander-Staudt (Sander-Staudt, n.d., in *The Internet Encyclopaedia of Philosophy*) captures care ethics as: "The moral theory known as 'the ethics of care' implies that there is moral significance in the fundamental elements of relationships and dependencies in human life. Normatively, care ethics seeks to maintain relationships by contextualizing and promoting the well-being of care-givers and care-receivers in a network of social relations."

Tjong Tjin Tai (2014:196-197) confirms the scope of care ethics as the reality of ethical challenges in practice and how these are addressed in practice. An important objective of care ethics is the protection and development of relations between people and the action within relations. The main aim is to address a moral dilemma in practice.

An important perspective on the scope of care ethics is added by Geybels and Van Stichel (2018:128-131). They stretch the view on care ethics by referring to *involvement ethics*. This shift is based on Gilligan's care ethics which has a more private or individual approach as opposed to Kohlberg's view on moral development, where justice is the highest ethical value. This represents a more public approach. Geybels and Van Stichel comment that Kohlberg and Gilligan each promote a particular approach: *justice* and *care* respectively. Geybel and Van Stichel differ, with their approach of the separation between private and public life. They argue that care is as much a public affair as it is a private affair. To bridge this divide, they are promoting the concept of *involvement ethics*. Their perspective should not be seen as a different perspective but rather as an emphasis that care is a public affair. Their perspective gives a voice to the voiceless. Firstly, the position of vulnerable people should be understood as the point of departure for care. Secondly, the vulnerable are challenged by the way in which society operates. Thirdly, the question is raised as to how the operation of society can be addressed and how the vulnerable can be mainstreamed into society.

What is important from their contribution is the emphasis on care as a public responsibility. Care is not something that takes place in the (dis)comfort of a private space. Care must involve all. This is a proactive pointer for the church. Firstly, care cannot be isolated from what is happening "out there".

"Out there" is the real world, influenced by ideology; most notably, political, economic and social ideologies. Secondly, a human rights culture is no guarantee that the vulnerable will be protected. The church as institution must care for the individual and must influence society to follow suit.

These contours of care ethics will now assist in identifying pointers for care ethics for the church's approach to healthcare.

7. Laying the foundation for care ethics as partner in the church's care for the elderly

Balboni and Balboni (2018) correctly argue that there is no reason for medicine and faith to be excluded. Faith resonates with the transformative role of illness, suffering and dying and promotes compassion instead of bottom-line care, whilst medicine reminds one of reality and that focus must be placed on what the real needs are. Instead of separating faith, spirituality, religion and theology from medicine, they argue in favour of integration. The dominant culture currently conditions us to think and act in ways based on dichotomies, divisions of labour and separated spheres of power. However, there is also the way of integration, unity and moving towards the "weaving of a seamless garment". Although science and technology have brought tremendous benefits to the patient, it also undercuts patient-centred care in medicine. Balboni and Balboni say that when contemporary medicine neglects or avoids spirituality and religion, it produces a significant void in the patients' experience of their care.

This paragraph will engage with the views of Geybels and Van Stichel, as well as Schotsmans and Burggraeve, to outline a framework for the church to care for the elderly.

The reason for engaging with Geybels and Van Stichel is because of their focus on religion and meaning as well as their approach to faith and science. Schotsmans' research on medical ethics aligns with social determinant needs in healthcare. Burggraeve is a leading scholar in the domain of care ethics.

7.1 Geybels and Van Stichel

Geybels and Van Stichel (2018) focus on *meaning giving* and *life orientation*. The Christian religion has an important contribution to make in relation to meaning giving and life orientation. To them, religion impacts on both private life and public domain. A culturally diverse society cannot claim that a particular group has the correct or the only perspective. Further, even within

the Christian religion there are different perspectives. It is in this context that their *dialogue* model is most relevant for the scope of this paper. Within their broader framework on religion and its influence on meaning giving and life orientation, they advocate a changing view on ethics and economics.

The reference to a *dialogue model* (2018: 65ff) is in the context of religion and science. The harmony model aligns the Bible and nature, two models through which we know God. What will the God of the Bible be, or how will He speak differently in the Bible than He does through nature? This model was particularly evident in the medieval period. In the so-called "modern times", a conflict model emerged. Galilei and Copernicus, for example, presented a different view on creation than the one that is found in the Bible. The conflict that has emerged is that only what can be measured and proven can be regarded as real, which brings biblical perspectives and proven reality into conflict. The dialogue model, influenced by Wittgenstein, amongst others, resonates in language. The grammar of the Bible is different from that of science. Science relates to cognition, while religion relates to practice, rites and values. Where science solves problems, religion deals with the mystery of life, happiness and suffering. The dialogue model argues in favour of a dialogue between the "world of religion" and the "world of science". Geybels and Van Stichel also refer to Thomas Kuhn, who observed that new theories are developed not because of verification or falsification but rather through new insights.

The implications of this approach can be extended to elderly care: the religious perspectives on suffering, value of life, respect for life, death and eternity evoke expectations, fear and joy in elderly people. These emotions are often challenged due to the absence of proper public policies and service delivery. In the realm of this paper where the focus is on healthcare, the application would be on what dialogue there is between the existential experience of the person and the realities of aging. In particular, the end of life is both a religious experience and a medical reality. What dialogue is taking place to comfort the elderly person to accept the reality of death, to address any fear the person may have, and to deal with the medical condition of the person? Each has its own domain, and à la Wittgenstein, its own grammar, which does not mean that no communication is possible between these two spaces. A dialogue between these spaces will comfort the elderly person facing (or nearing) the end of life.

Their second contribution is equally valuable. The current economic sphere has reduced human beings to *homo economicus* (Geybels & Van Stichel, 2018:164ff). This is supported through the existence of many networks. On

the down side, the economic meltdown questions the economic literacy to make informed decisions and secure investments, for example. In addition, there is uncertainty related to the work place and to social security. The critique from Christian ethics is obvious: a person is reduced to an economic object only and the focus is now on the individual and not the fellow person. A Christian-informed social ethic will promote humanity and community. The interest of the one can never be at the expense of the other. The economy is about prosperity and responsibility. There are stakeholders and shareholders. A Biblical model will promote engagement with the poor and the marginalised; it will address the possession of goods and the rightful use thereof. Geybels and Van Stichel (2018:170) promote human dignity and general welfare. Such an approach will oppose the reduction of a person to a mere economic value. They argue in favour of love (agape = neighbourly love) in the economy. It is here that relationships, a core value in care ethics (my addition), are promoted. The core of the argument is that people should not be harmed through economic transactions. The Focolare movement (unity of spirit) has as aim to concretise the love of God in daily life through care and love of others.

Back to the cost of elderly care. This approach, humanity and community, will not focus exclusively on providing for the needs and delivering the services of the elderly only, but will also add to the meaningfulness of elderly people's existence.

The pointers taken from Geybels and Van Stichel (2018) suggest that (a) there should be a dialogue between the different spaces of experience and reality, (b) economic status can never reduce people to their needs and wants only, (c) meaning and care should be added to people's lives, and (d) there should be stimulation of a new way of thinking and doing.

7.2 Schotsmans

Schotsmans reviews the role of the church in healthcare. Although the context is Catholic Flanders, the observations with regard to the church's role in healthcare are useful for the scope of this research. His reflections on 25 years' worth of observations are also useful.

A history of medical ethics will account for huge agreement within the Christian community. Examples are numerous. Schotsmans (2012:24ff) identifies the opportunity to give life (organ transplantation), equal access to medical care (healthcare), caring for people nearing end of life (palliative care) and that life has an end (no unrealistic therapeutic intervention). There are also major differences. These differences emerge from bio-ethics, in particular beginning

and ending of life (Schotsmans, 2012:53 ff). It is evident that the church has not and cannot express herself on all the new developments within the medical profession, as cutting edge developments very often exceed the body of knowledge available on a particular matter. In addition, even within church policy there can be differences of opinion and or approach. Secondly the church, because of its basis of existence as faith-based institution, does not have the skill or the knowledge to address a particular new development. It should not be forgotten that policy and implementation are not easy. (This of course, is not limited to the church only). Thirdly, the church has established a good track record of caring for the vulnerable and the sick. This observation culminates in the title of Schotsmans' book, *In good hands*.

A number of comments may inform this study on the elderly. To start with, the emphasis is on the care of vulnerable people. Here, as in other care situations, the relationship between patient and doctor is one of trust and responsibility. The humanity of the patient should be paramount. Ethical intention is therefore essential. The application of imbedded value should be everyone's commitment. It is here that there is a major challenge, as there may be differences in the sharing and promoting of joint values (Schotsmans, 2012:19-21). Secondly, a Christian-informed ethics is not an absolutely individualistic culture (the "I" culture). The individual has become the ethos of the dominating culture (Schotsmans, 2012:21-22). Thirdly, in healthcare, mercy, service and humanity should prevail (Schotsmans, 2012:24). Fourthly, especially in the context of euthanasia, the role of purposeful care (meaningful closeness) whilst a person is dying should be promoted. Schotsmans refers to the extending of palliative care through medical, physical, relational and spiritual support. He is mindful of how this extended support could clash with self-determination. This does not negate meaningful closeness through the presence of people (Schotsmans, 2012:101-103). Fifthly, people with dementia should always be treated with dignity. The Christian community holds to the view that a person is created in the image of God. Quality of life remains important and cannot be ignored. But this is challenged by the Christian community's belief that all life, regardless of its quality, deserves respect (Schotsmans, 2012:122). To him it is not about respecting autonomy but about integrating support and responsibility. Sixthly, it can never be about a deontological approach (the quality of the act is more important than the consequences), as this is too much of a statistical approach. Instead, he promotes a growth ethic. He borrows from Roger Burggraeve the idea that a person not only has limitations but also opportunities. This calls on the possibilities for growth. The reality of a person's context is reviewed and then the best means are sought to reach the quality possible for that person's life.

Mercy is to not overestimate or underestimate the possibilities of a person (Schotsmans, 2012:136-138).

Schotsmans (2018:37-38) advocates the promotion of a quality healthcare system through what is generally known as *evidence-based healthcare*. To realise this (in the context of a country) there should be a scientific needs analysis to identify the needs of a society and the testing of treatments that can address its needs. A range of actions is required here: it is the responsibility of the doctor to use diagnostic or therapeutic techniques that can promote the health of the patient. Hence treatment should be directed at the needs of the patient. Finance must be available to support a healthy society. The innovations of pharmaceutical companies must have healthcare in general in mind. Needs, affordability and profit must be aligned.

What is useful within the scope of this study is the reality that there is not always a reasonable and/or acceptable explanation for all developments, most notably for growing old. The emphasis on vulnerability sensitises the faith community on the temporality of life. Life as we know it, is limited, and it will eventually come to an end.

7.3 Roger Burggraeve

Burggraeve has developed an ethical framework for "meeting" the "other". In developing his own ethical discourse, he is in particular influenced by Emmanuel Levinas (see Vanlaere, Burggraeve & Lategan, 2019:110ff). Although his framework fits into the broader concept of *care ethics*, this ethical framework is known as an *ethic of growth*. Within this ethical framework there are three notable concepts relevant for this study, namely (a) meeting a person in the situation that he/she is, (b) knowing what is doable in this situation, and (c) supporting the person from where he/she is to *grow* to the ideal situation. His ethical approach is specifically related to vulnerable people. Within the broader frame of a Christian ethic, it will always be an ethic of *redemption* (Burggraeve, 2016:138). Ethics has intention and acts. Heart and hands. Everything a person does, has consequences (Burggraeve, 2000a:16).

Of particular importance, is to assist the person from where he/she is, to grow to the ideal situation. For this to happen, one needs to meet a person in his/her situation in order to reach out to the real challenges that a person is experiencing. This evokes an ethic of compassion and calling (Burggraeve, 2000b:98-101). In Burggraeve's reflection on the merciful Samaritan, the focus is on the stranger, the other (Burggraeve, 2000a:73).

The Jews had to learn that neighbourly love includes the stranger. But the first person also engages with the other person from his/her own mortality and imperfection, hence an own vulnerability (Burggraeve, 2000a:75). The first person also needs to grow from where he/she is, to the ideal position. Of importance is that the other also enters the first person's life. Although this entry into a person's life is unintentional, it is not without its own consequences. According to the parable in Luke 10:25-37, this engagement was unplanned on the part of the Samaritan (Burggraeve, 2000a:79). Based on these events, he concludes that ethical behaviour towards the other is not motivated by a subjective ethical orientation to do good to the other but because of the meeting with the other (Burggraeve, 2000a:86). This makes a person responsible (Burggraeve, 2000a:87). This meeting is a face to face encounter (Burggraeve, 2000a:81). Meeting the other is not always a pleasant encounter (Burggraeve, 2000a:83). This encounter appeals to a person and holds that person responsible (Burggraeve, 2000a:7). This responsibility becomes a person's mercy towards the other (Burggraeve, 2000a:89). Showing this mercy makes the person him-/herself vulnerable too. Ethics also highlights the value of each person (Burggraeve 2000b:123). Touching another person is the basis of mercy. Caring for other people is associated with a womb which symbolises the intimacy of care for the other (Burggraeve, 2000b:195-197). Mercy is a reflection on what God is doing.

People are often at the ethical minimum (*minus malum*) and should be assisted to experience life at a different, better level. This is the core of Burggraeve's growth ethics (Burggraeve, 2000b:259). The reason for doing this is to attain the best situation possible and to realise love in another person's life. This is the smaller good. This is not the ideal, but it is what is possible now. This approach is linked to the Christian realisation of the complete good (*vere bonum*) (Burggraeve, 2000b:262). This is part of a redemption ethic. Here too the ultimate objective is to grow to the realisation of love (Burggraeve, 2000b:263). Redemption ethics are imbedded in Christ as saviour Who also redeemed our ethical life (Burggraeve, 2000a:16).

An additional perspective is highlighted: the smaller good to others. This is what one can do when a society or its politics cannot deliver on the human obligation to do good to the other. He refers to this approach as a goodness without borders and labels it as a *bonte folle*. The translation means it is a kindness (*bonte*) without reason (crazy – *folle*). The interpretation means it is kindness for which there is no explanation, except our deepest humanity (Burggraeve, 2008:113).

8. Application

This study has outlined that care ethics is a relevant context for elderly healthcare as it is about addressing the ethical challenges in (health)care, the building of relationships and the recognition of the vulnerability of the elderly. Care ethics is practical, hands-on and directed at people (see paragraph 6).

Three perspectives on elderly healthcare were linked to care ethics, namely:

a) Care takes its origin in the vulnerability of people and the relationship between the care-giver and care-receiver is essential.

b) Because elderly people are vulnerable, their nearing the end of life or the end of life itself requires a relationship between care-giver and care-receiver.

c) The elderly cannot be treated without compassion and cannot be left in their despair. Their experience of the *minus malum* should be extended to *vere bonum*. Here growth supported through mercy is an essential ethical imperative.

From the arguments presented, it has been made clear that the church has an active role to play in the healthcare of the elderly and that there should not be any void between religion and healthcare, or between theology and medicine.

These arguments suggest the following markers for the church's participation in elderly persons' healthcare:

- **The core of healthcare is caring for vulnerable people**

Caring for vulnerable people is especially important when the people happen to be elderly. Their phase in life can be identified as nearing the end of life. Very often, the elderly is also at the very end of life. Care as relationship is essential in dealing with vulnerability. Geybels and Van Stichel have claimed convincingly that dialogue between experience and reality is critical to avoid a stark divide between experience (for example the belief that God will cure cancer) and reality (for example dementia). Balboni and Balboni point out the lack of separation between what is fact (for example kidney failure based on evidence-based medicine) and what is existentialism (anxiety about the unknown, or about what will happen to me when I die). Burggraeve's framework of growth ethics is dynamic in so far as it advocates for a better space – to move (emotionally/your perspectives) from where you are to where you want to be/can be. This is a basis for pastoral care: to understand the person in his/her situation and then to move to a more desired situation through mercy and love. This is the hope that is associated with redemption.

In pastoral care the elderly person's healthcare is often limited to the end of life. Although it is true that the end of life is central to all elderly people's care, this does not mean that there is no growth required in this situation. Schotsmans' reference to closeness is relevant here.

- **Elderly people are defined by their circumstances**

The nearing end of life and the end of life itself contribute to the special (health) care needs of the elderly. Annemans (2016), amongst others, unpacks the economic realities of elderly healthcare. The solution to this reality is complex and beyond the scope of this paper. However, Geybels and Van Stichel (2018) are correct to guard against a reduction of the elderly community to their economic needs. No (elderly) person can be reduced to an economic object (*homo economicus*). The Reformed philosophical tradition will confirm that describing people by their attributes cannot replace humanity. In all elderly healthcare is it a person who requires care.

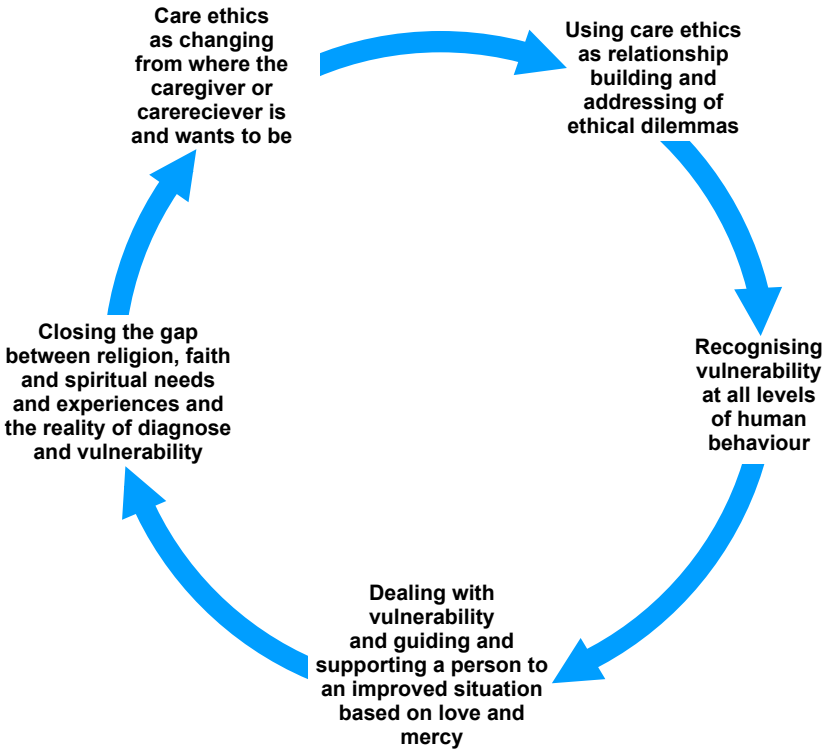
- **Relationship building through care**

Schotsmans and Burggraeve confirm that caring for the other does not only mean meeting, engaging, touching or caring for the other; it also has a change effect on the caregiver. A major challenge in healthcare is the one-way traffic from the care-giver to the care-receiver. Burggraeve's interpretation of the parable of the merciful Samaritan confirms the compassion for the wounded man. Through the concept of meeting the other, the care is no longer a matter of "I have to" but rather "I want to". This is a "vulnerable responsibility".

- **Care is more than attending to the physical needs of the other**

Compassion for the other (here the elderly) makes the difference (see Burggraeve's reference to *bonte folle*). Personal involvement cannot be waived. Once again, this compassion is not a matter of one-way traffic only. Vanlaere, Burggraeve and Lategan (2019:83) focus on caring for the care-givers. Society has a very specific expectation of care-givers. Moving outside the societal boundaries is often seen as unacceptable. Yet care-givers have needs, feelings and expectations too, and their situation makes them vulnerable. It is expected of people to behave in a given manner. Good care takes a person's experience seriously: and experience is intrinsic to a person's self-respect and self-confidence. This debate is not limited to elderly people only. It relates to people at all stages of life. What is (more) challenging though, is the vulnerability of people with dementia. Quite often, they cannot make any real input regarding their desire to live, and they are not able to request assisted ending of life. It is here that "surrogate decision making" is coming to the fore.

These markers suggest the following framework for the healthcare of the elderly based on care ethics:



Framework 1: Care ethics for elderly people

9. Conclusion

This study has outlined the reality of a growing elderly community and the impact it will have on society and in particular on healthcare. An argument has been presented that the church has a role to play in the healthcare of the elderly, although, as confirmed by data bases, this role has not been the focus of research. The constructive role that religion, faith, spirituality and theology can play in healthcare was further highlighted. The contributions by Geybels and Van Stichel, Schotsmans and Burggraeve were used to inform the church's role in healthcare.

The outcome of the research defines four pointers:

- The core of healthcare is caring for vulnerable people.
- Elderly people are defined by their circumstances.
- Relationship-building between the elderly and the care-givers is through care.
- Care is more than merely attending to the physical needs of the other.

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