1st Sunday of Advent (B) 2014
Forty Martyrs'; St Bede's

Jesus will come in glory and bring about the end of this world and inaugurate the Kingdom of his Father. That is the belief of the Church. But for many millions of people, and perhaps for all of us, the end of our world in death will precede our meeting with the Lord of glory. The message in either case is the same: Be ready; you do not know the hour. The day will come like a thief in the night.

In the past few weeks I have led the funeral services for half a dozen people younger than me. As a nation we are living longer lives than people have ever lived before, but death when it comes is generally a surprise. Even in old age people can die unprepared; defiant of mortality.

Dr Atul Gawande is an eminent surgeon and writer; and now a broadcaster – he is giving the Reith Lectures on BBC Radio 4 at the moment (each Tuesday from last week at 9.00 and on the i-player). He has written a book of great importance. It is a worthy successor to "*On Death and Dying*", the ground-breaking study by Elizabeth Kubler-Ross who in the 1950's listened to patients (a total novelty) who were terminally ill and mapped the stages we go through, which can help us die a good death, accepting our mortality; and to Sherwin Nuland's "*How we die*", a classic of the 1990's, which tells us what happens to the body as illness and age take their toll. *

Dr Gawande's book, "*Being Mortal*" deals with the situation in the United States but much of it translates easily into our situation. It is an examination of the way medical science, doctors and systems, deal with the elderly as they grow old and their needs multiply. Doctors see death as failure; and strive to keep patients alive, at whatever cost is paid in terms of the quality of life of the patient. There are harrowing stories of doctors giving over optimistic predictions of what various treatments will achieve, which often times are fantasy, and can cause the sick person great pain and distress in their final weeks. We need to ask ourselves searching, hard questions about what we want in our final days; what quality of life we will settle for; and what we will forgo to achieve that.

An alternative to doing anything to keep alive is provided by the hospice movement, both by care in a hospice, and hospice palliative care experts visiting people in their homes. The effects have been manifold, with significant reduction in costs, people more content in their situation, and, astonishingly, longer lives. "The lesson seems almost Zen", writes Dr Gawande, "you live longer only when you stop trying to live longer." [p178]. He might have added that we find that lesson in the Gospels too. Less surprisingly, a major factor in the rise in patients' sense of satisfaction was having someone listen to them. "Somehow that was enough – just talking." [p177]

Dr Gawande also looks at the way we treat the elderly and enfeebled. We have, I expect, all visited nursing and care homes, where the smell of urine was

overwhelming; and the clients have been sat in circle of arm chairs, with a TV blaring, unwatched, and there they snooze and one may shout and gradually all lose all will to anything. Alan Bennett has a accurate but painful description of death by starvation in his mother's care home in Weston-super-Mare. There is no one to feed the patients and the plate is placed before them and later taken away untouched. **

Dr Gawande gives a potted history of attempts to improve this lamentable situation, and the remarkable successes that have been achieved, by which old and infirm, and people with mobility issues have been able to be supported in their homes, and thus retain their independence, and crucially, maintain a purpose in living, which quickly disappears when people are moved to nursing facilities, which however good, emphasise the need to be safe, over the necessity of being happy.

He tells the story of Dr Bill Thomas who, aged 31, took on the job as medical director of a nursing home in up-state New York. There were eighty severely disabled elderly residents; four out of five had Alzhiemer's disease or other cognitive disability. He was quickly very depressed. He saw despair in every room. He sought an answer to the lack of spirit in the residents and medically examined them all in search of some explanation. He only succeeded in putting the medical bills up and driving the staff crazy. Then he had an idea. He decided that what was missing from the home was life. A born salesman Thomas got everyone on board for his idea. He wanted to attack what he called “the three Plagues of nursing home existence – boredom, loneliness and helplessness”. The attack was based on bringing life to the place. He had green plants put in every room, a lawn was taken up and a vegetable and flower garden created; and he brought in dogs and cats and birds. Lots of them, four dogs, two cats a hundred birds who were delivered before their cages were. Later there would be rabbits and laying hens, and lots of interaction with children. It was a big bang approach which led to total pandemonium and numerous crises.

But as things settled down, a change was effected: “People who we had believed weren't able to speak started speaking,” Thomas said. “People who had been completely withdrawn and non-ambulatory started coming to the nurses' station and saying, 'I'll take the dog for a walk'. All the parakeets were adopted and named by the residents. The lights turned back on in people's eyes.” [p122]. Moreover, compared to a nursing home close by the prescriptions required per resident fell by half; the total drugs cost fell to a third (38%) of the comparison facility. Deaths fell 15%. Thomas' explanation: the residents had a reason for living.

This is, in my view, a very important book. It is easy to read, illustrated with stories which involve people with whom we can readily relate, including the author's own father whose dying is closely recounted. It deals with matters of huge concern and consequence for each of us as individuals who will be faced with hard choices and, at the moment, little wisdom to help inform those choices; and for us all as a society which has to accept limits on National Health spending, yet find a way to fulfil peoples' needs at the most vulnerable and probably disorientated, time of their lives.

Parliament keeps returning to the issue of 'mercy' killing. Dr Gawande makes the point that in Holland, one of the countries which allows the prescription of lethal doses of drugs to remove suffering by killing, which has employed this system for decades and has seen no serious opposition to it, has seen its use increase so that by 2012 one person in thirty-five died by assisted suicide. He sees this as a measure of its failure. “Our ultimate goal after all.” he writes, “is not a good death but a good life to the very end. The Dutch have been slower than others to develop palliative care programmes that might provide for it.” [p245]

There is the nub: More 'mercy' killing leads to fewer resources given to palliative care, the very thing that can reduce costs and increase happiness at the end of life. Which is the merciful, the compassionate path? We need to be demanding that we live a full life to the end as far as possible. That must be our aim for ourselves and for all others. That is how to show mercy and love, compassion and care. Our God given purpose is surely to live life to the full here on earth, before passing on to the fullness of life when the Lord comes in glory.

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Atul Gawande, *Being Mortal, Illness, Medicine and What Matters in the End*, Profile Books, London, 2014
Elizabeth Kubler-Ross, *On Death and Dying*, Scribner Book Co, New York, reprint 2014.
Sherwin Nuland, *How We Die*, Vintage Books (Random House), New York, new ed. 1997.

** Alan Bennett, *Untold Stories*, Faber & Faber, London, 2005, pp114-115