

Towards a ‘Social Anthropology’ of End-of-Life Moral Deliberation: A Study of Australian Salvation Army Officers

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Abstract

A research project by the Schools of Theology and Psychology of Australia’s Charles Sturt University surveyed a large sample of Salvation Army officers. This article considers survey responses to two questions relating to end-of-life care: the use of pain medications that may shorten life, and the cessation of fluid and food intake. The results of the analyses are evaluated in terms of Michael Banner’s proposal that moral theology should more assiduously converse with ‘patient ethnographic study’, which the survey instantiates to some extent. Banner’s proposal and the results of the survey are contrasted to Peter Singer’s analytical moral philosophical dictums on end-of-life care. The results are also compared to a metastudy by Andrea Rodríguez-Prat and Evert van Leeuwen of 14 ethnographic studies of those who wish to hasten death at the end of life. We conclude that respondents exemplify a form of moral reasoning that is embedded within Christian spirituality; counters the assumptions of Singer’s approach; contrasts the diminishment of ‘meaning’ at the end of life, as seen in Rodríguez-Prat and van Leeuwen; and deserves further respectful ethnographic study.

Keywords

Salvation Army officers, end of life, withdrawal of treatment, burdensome treatment, euthanasia, double effect, social anthropology

1. This article comprises part of a wider project entitled ‘End of Life Care for Salvation Army Officers’, led by Professor Bruce Stevens, Wicking Chair of Ageing and Practical Theology, Public and Contextual Theology Research Centre, Charles Sturt University (CSU) Canberra

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Introduction

We may reasonably posit that practitioners and recipients of end-of-life care have different daily concerns than most readers of this august journal. Considered deliberations about morality such as found in these pages do not always bridge to the quotidian acts, thoughts and feelings located within physical decline and onset of death after a long life. This article attempts such a bridge, in conversation with a *survey*, a *proposal*, and an *interlocutor* who arguably represents what has made the bridge hard to cross.

The *survey* was of a particular group of religious believers: older Australian Salvation Army officers. It was conducted to inform policy for the care of older Salvation Army officers by understanding their ageing and spirituality through their own testimony, giving a sound evidence-base for reflection on their spiritual needs and their needs as older people.

The *proposal* was put by Michael Banner in his 2013 Bampton Lectures, published as *The Ethics of Every Life: Moral Theology, Social Anthropology, and the Imagination of the Human*.² In essence, Banner believes that moral theology has become captive to a dialogue with a particular instantiation of moral philosophy—namely, a subset of early twentieth-century Anglo-American analytical philosophy that was heavily indebted to Hume and Mill and their respective dialogues with Kant; and later, logical positivism. This line of analytical philosophical thought has in turn set the main boundaries of modern professional ‘bioethics’. He believes the discourses in morality that this inheritance has trained us to have ill-equip us to care for actual people (such as those surveyed). The philosophical discourse fails us because it is devoid of any thick description (such as is intended by the survey) of real people.

The *interlocutor*, then, is the Australian philosopher Peter Singer, whose preference utilitarianism sits within that mode of philosophical discourse. I will suggest that whatever its merits, Singer’s approach actually delivers him into a kind of ‘mind-blindness’ toward others (such as those surveyed), the same kind of ‘mind-blindness’ as also evidenced in an egregious episode supplied by Banner.

The Survey

A project entitled ‘End of Life Care for Salvation Army Officers’, led by Professor Bruce Stevens and Dr Rhonda Shaw of Australia’s Charles Sturt University

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2. Michael Banner, *The Ethics of Everyday Life: Moral Theology, Social Anthropology, and the Imagination of the Human* (Oxford: Oxford University Press, 2014).

(CSU),³ set out to determine the expressed thoughts and needs of these people, ultimately to inform and improve their care in independent living and in high-dependency settings. Answers to an 11-question survey on end-of-life care were returned by 270 working and retired Salvation Army officers from the Australian Eastern Territory, an administrative region of the Salvation Army in Australia.

For the Salvation Army, an officer is '[a] Salvationist who has been trained, commissioned and ordained to service and leadership, in response to God's call', and is a recognised minister of religion.⁴ The Salvation Army's origins were in the nineteenth-century ministries of Protestant evangelicals William and Catherine Booth, and its ministry continues today in 131 countries. 'Army' doctrine lays out mainstream Reformed Protestant affirmations such as a divinely inspired canon; one Triune God, and the incarnate Son Jesus Christ; fallen, guilty humanity offered salvation through the atoning work of Christ; lives justified by grace and expressed through faith, repentance and sanctification; and traditional Christian personal eschatology premised on the soul's immortality, the body's resurrection, and divine judgment to salvation or reprobation.⁵ Work in Australia officially began in 1881, and today, Australian officers comprise some 877 active and 836 retired.⁶

Officers all undertake this Covenant:

Called by God to proclaim the gospel of our Lord and Saviour Jesus Christ as an officer of The Salvation Army, I bind myself to him in this solemn covenant; to love and serve him supremely all my days, to live to win souls and make their salvation the first purpose of my life, to care for the poor, feed the hungry, clothe the naked, love the unlovable, and befriend those who have no friends, to maintain the doctrines and principles of The Salvation Army, and by God's grace, to prove myself a worthy officer. Done in the strength of my Lord and Saviour, and in the presence of leaders, officers and fellow cadets.⁷

On the face of it such description seems unremarkable. People believe things; Protestants believe specific things; some become ministers. A brief precis of such lives too easily seems uninteresting, particularly in a cultural milieu that valorizes several domains of activity well ahead of long-term, covenant-making religionists. But that attitude elides that precisely here do we find an identifiable group whom we may expect are richly embedded into forms of life generating specific approaches to its end. Both the practices and what generates them are inherently interesting, even putting aside the obvious value of learning how such people may better be cared for.

The survey (see further Appendix A) was of active and retired officers aged between 30 and 93 years, comprising at least 153 males and 102 females with 15 respondents not indicating gender. Their average age was 66, with a standard deviation in the sample of just under 14 years; therefore roughly about 85% of the sample was above 54 years old.

3. See further n. 1, above.

4. Angela Strickland (ed.), *The Salvation Army Year Book 2019*, Kindle edn (London: Salvation Books, 2018), loc. 603.

5. Strickland, *2019 Year Book*, *passim* and loc. 368.

6. Strickland, *2019 Year Book*, loc. 1900.

7. Salvation Army, "'My Covenant'—The Officer's Covenant"; online: <https://www.salvationist.org/poverty.nsf> (accessed 1 March 2019).

In terms of relationship status, more than 70% of the sample were married, 11% single, 12.5% widowed, 2.7% divorced, and 2.4% separated. A few completed their education after primary school (3.9%), most had a secondary-level education (52.9%), and a large minority had completed a university bachelor or postgraduate degree (41.3%).

The survey instrument used was based on World Health Organisation (WHO) inventories, so validated as to enable data collection of statistical significance from a quantitative perspective, and enabling comparison to similar data collected worldwide. As a short survey to a non-technical constituency, it sought to elicit attitudes and convictions about several important later-life experiences and included the following questions:

- What relationships do you consider important to you in your end-of-life care?
- How do you see these relationships being supported at this time?
- What do you think your most important emotional needs during your end-of-life care will be?
- How do you see these needs best being met?
- Can you describe what for you would be your desired end-of-life experience?
- What expectations do you have of chaplaincy services in end-of-life care?
- How would you like to express your spirituality at the end of your life?

Responses to these questions have been analysed in companion papers arising from the study including ‘Differential Influences of the Facets of Religious and Spiritual Beliefs on Salvation Army Officers’ Quality of Life’⁸ and ‘Unique Needs: Salvation Army Officers in Retirement and End of Life Care’.⁹

Given moral complexities surrounding the process of death, two related questions demanded a different kind of analysis, which is the focus of this article. The project leaders conveyed the results to this author for moral-theological analysis and reflection. Questions 5 and 6 of the survey asked:

5. What is your view on using pain medication during your end-of-life care knowing whilst relieving suffering and pain this may also hasten death?
6. What is your view on ceasing oral food and/or drinks in the final days of life?

Both questions are deliberately open, and neutrally phrased, so as not to indicate any moral bias. Each question poses in non-technical terms an aspect of two moral debates about the end of life.

- Question 5 tests whether the respondent makes a distinction of moral significance between intention and foresight in relation to death. The question is reminiscent of a

8. Rhonda Shaw et al., ‘Differential Influences of the Facets of Religious and Spiritual Beliefs on Salvation Army Officers’ Quality of Life’, *Journal for the Study of Spirituality* 8.1 (2018); online: <https://www.tandfonline.com/doi/full/10.1080/20440243.2018.1431174>.

9. Bruce Allen Stevens et al., ‘Unique Needs: Salvation Army Officers in Retirement and End-of-Life Care’, *Journal of Religion, Spirituality and Aging* 30.1 (2018); online: <https://www.tandfonline.com/doi/full/10.1080/15528030.2017.1344178>.

supposed ‘principle of double effect’ where an action is regarded as licit even if a bad effect arises from it, as long as the effect is foreseen but not intended. Oliver O’Donovan’s brief analysis of the ‘principle’ contends that it only has value in consideration of some forms of death, and cannot take the status of a formal moral ‘principle’ that is generally applicable in moral discourse.¹⁰ The philosophical and moral significance of distinguishing intention from foresight remains interesting and important though, whatever we may conclude about a ‘principle’ and a ‘double-effect’.

- Question 6 lies at the less controversial end of a cluster of debates over the provision or not of ‘burdensome’ treatment at the end of life. If we accept that death is not something within human power to prevent, it follows that many medical interventions become ‘treatments’ no longer and deteriorate into mere impositions of further suffering, such that their withdrawal is indicated.¹¹ Hydration and nourishment through forms of intubation represent a liminal space between ‘care’ and ‘treatment’; but Question 6 pertains to oral intake of food and water. These are not ‘treatments’ but activities of daily life that the dying person controls, and their cessation may be regarded as a precursor to the onset of inevitable death. However, the indeterminate subject of the participle ‘ceasing’ also invites the respondent to offer an opinion about whether a *carer* may withhold sustenance and hydration. The question therefore queries respondents’ attitudes both to the way they eat and drink immediately prior to death, and to the obligation upon their carers to provide sustenance.

An initial analysis was performed on the results of each question aided by the software package NVivo.¹² This software enables thematic analysis of unstructured qualitative data. In this case, inductive thematic analysis of each question makes it appropriate to group responses of participants according to (a) those who signalled agreement; (b) those indicating some form of objection; and (c) some other response.

To give some sense of the people surveyed, a brief analysis of responses to each question follows, including a representative assay of responses. These retain the misspellings, grammar and syntax of the original data that will not be indicated by ‘*sic*’. The presentation following invites either meditation on each cluster of responses (all italicized), or a quick scan of the summary headline of each point.

Thematic Analysis of Responses to Question 5 (on Medicating Pain)

For participants who agreed to the use of pain medication during end-of-life care, many responses outlined outright agreement ($n = 71$; e.g. ‘*Yes please*’, ‘*Very much agree*’, ‘*No problem*’, ‘*Necessary*’).

10. Oliver M.T. O’Donovan, *Resurrection and Moral Order: An Outline for Evangelical Ethics* (Leicester: Apollos, 1994), pp. 192–94.

11. See further Rachel A. Ankeny et al., ‘Religious Perspectives on Withdrawal of Treatment from Patients with Multiple Organ Failure’, *Medical Journal of Australia* 183.11 (2005), pp. 616–21; online: <https://www.mja.com.au/journal/2005/183/11/religious-perspectives-withdrawal-treatment-patients-multiple-organ-failure> (accessed 13 March 2018).

12. NVivo version 11.4.0, QSR International; online: <https://qsrinternational.com/nvivo/nvivo-products>.

- Agreement was often premised on lessening suffering and improving quality of life ($n = 89$), especially for the sake of families witnessing the process of death: *'Quality of life is of paramount importance not length. Would prefer to have pain relief and a shortened life than linger on in agony.'* *'I think there is no need for pain & suffering during end-of-life care. Medication is merciful. I believe death is in God's hands.'* *'Death is certain, I believe giving people relief from the pain in their mortal bodies is kind and humane, not just for the person, but their family too. (I don't advocate euthanasia, but helping them be at peace when they die, not in agony.)'* *'Relief of pain is important for quality of life regardless whether it hastens death or not. Prolonging life without any quality of life has more impact on relatives than patients.'* *'I do not want to experience a painful death. I want my family to see my death as an extension of my living.'* *'I want to be comfortable and want my family to see that I am free from pain and suffering. By this stage in life, I am not too concerned that pain medication may rob me of a day or two.'* *'Having been through this situation with family members—I agree with pain medication to lessen my own pain & suffering also for the sake of family members who are observing the suffering.'* *'This is a humane expression of a deep level of care and respect.'* *'The less pain the better so ethical and careful access to medication is paramount. My concern is that individuals will still have the right to choose. My hope is that decisions around death and dying remain with the individual and their nominated family members.'*
- Many responses ($n = 55$) indicated agreement premised on some conception of necessity and/or appropriateness, often predicated upon expert medical opinion: *'Appropriate relieving of suffering and pain wanted.'* *'I don't object to any careful, considered decision given by the person in charge knows what is best.'* *'Happy to follow the Doctors advice. Always seeking God's hand to be on me—daily praying for His protection and guidance. I've been fortunate to live in a country that seeks to "do the best in health" for its people.'* *'I would be well to take advice from the medical professional, although my wife wants no pain medication, if she gets bad enough to have it suggested, I probably would take it.'*
- Some participants focused upon balancing the need for pain medication with the consideration neither to prolong life unnecessarily nor, for some, to hasten death: *'I would trust the judgement of the medical professionals. On the flip side, I would not want my life extended by excessive medication. Happy to let nature take it's course.'* *'Only what is necessary for comfort and ease, not to keep on living.'* *'If I am in much pain, I would welcome the pain medication. If pain and lack of cognition dominate my life at the end, I would prefer death to hasten.'* *'My only concern is that medication is not used to prolong my life if i am not coherent. I believe that keeping people alive with medication with no dignity is just as sinfull as taking people lives through youthenasia.'* *'It is appropriate if it relieves pain, but not as a form of assisted suicide.'* *'[Q]uality of life vs quantity—when there is truthfully no quality without analgesia eg morphine—it should be able to be used.'* *'Palliative care is an area that I have recently experienced with my wife. I found that the measure taken to ensure her freedom from stress was administered with great care and measure. Pain is a subjective experience and some have a higher threshold*

than others thus it follows that quality of life is also a variable. My personal view is that whilst there remains a possible reaction, interaction and or communication between the person facing death and their surroundings which provides pleasure and enjoyment of life then control of pain remains critical. The aim should be to experience freedom from debilitating pain even if the adverse effect of bringing death closer is experienced. Excessive use of pain medications beyond this measure would, I hope, never be administered.'

- Others in this group also expressed a desire to be involved, alongside the doctors and their family, in the decision-making processes: *'I do feel the question has to be resolved in the not to distant future—Life prolonging measures are as vital to human happiness as life termination. The balance thus to be worked out by the medical in close harmony with family to be full trusted by all sides involved.'* *'This needs to be balanced and sensitively approached. Clear information of pros and cons needs to be articulated openly.'* *'I would want to be consulted about these decisions at the time, or have those who know my wishes consulted. I believe I would want pain relief, but would want choice over how much and when for as long as possible.'* *'I'd like to have a say at the time if that were possible. Otherwise that would be the decision of my family, one of whom, a nurse, has medical power of attorney for me.'* *'Happy with this. This process needs discussion and development so that "others" are not overburdened by the process.'*

If we may hazard a synthetic evaluation of these responses, they evidence an ample capacity for nuanced moral deliberation about when life is ending, the extent and limits of authority constituted by medical knowledge, and the implications of death for an intimate community of carers. While there is cognizance of the travails of close loved ones, the language of 'being a burden' is generally not deployed here; and the concept of it is only a provisional element of moral analysis rather than determinative for it.

Interestingly, a small number of participants disagreed with the use of pain medication during end-of-life care ($n = 9$). Their responses viewed pain medication as deleterious, since it may either hasten or prolong death, reduce awareness, drain family and friends, or go against God's wishes.

- Only one long response pivoted on the problem of suffering and burden, and ambiguously at that: *'Quality of life more than quantity of life is more important to me. Advances in medical science have made significant improvements in the capacity to sustain and prolong life. In doing so, new challenges in palliative care confront us and begs the question: "how can one die with dignity"? As one who has a strong belief in death being the gateway to eternity, where there is no more sorrow, suffering or pain, why would I wish to linger longer? Emotional and physical drain on family and friends increases as quality of live decreases. The longer I live, the more it costs too!'*
- However, the negative responses, while formally phrased as disagreements, arose from moral reasoning that does not accept 'burden' as a determinative moral 'problem': *'[I] think medical staff have become too clever and want to "fix and heal" all the time and that sometimes we keep people alive longer than*

God intended. 'I would have to be in extreme pain before I would allow it.' 'I do not agree with something that may hasten death.' 'We cannot possibly experience peace and hope if doped up with injection. I can understand for those caring and sitting by it probably would be easier for them and less disturbing.'

Although these latter responses are formally negative, they notably share similar moral calculus as the responses of agreement. That is, they also exhibit a radical acceptance of when life is ending; they point to bounds upon the extent and limit of medical authority (and so resist 'medicalization'); and they indicate an awareness of the implications of their death upon their intimate community of carers.

Other indeterminate responses focused upon respect of an individual's beliefs and wishes ($n = 9$), including their spiritual beliefs ($n = 5$).

- A selection of responses delegated moral decision to the autonomy of every dying person. *'I believe it's the choice of the individual. Hopefully it's something I've talked about with my loved ones before I become incapacitated mentally.'* *'This is a personal choice. I feel that is a choice I would make to give me a dignified, pain free exit from this mortal coil. If you are dying, it will occur with or without medicinal help. Why suffer, and make those who care suffer.'* *'If the person is able to make decisions let the person decide. If the person is beyond making decisions for themselves give them pain medication and make them as comfortable as possible.'*
- Some relegated autonomous moral discernment to discernment of the will of God: *'God gives life and God is the one to take it.'* *'My husband and I would pray about this and do as God leads.'* *'if my body is giving out then I am prepared for my eternal home and I don't want to delay the inevitable.'* *'The presence of the closest relative ... holding hands and speaking of God's provision eternally. If the patient has no real faith then it should be the responsibility of a loved one or even a pastoral care worker to explain the way of salvation through sins forgiven and faith in the sacrifice of Jesus on the cross of Calvary. The blood of Jesus Christ God's son was shed to redeem the person and every other person.'*

These examples evidence our cultural respect of autonomy, and gesture toward orthodox Christian accounts of the final agency of God.

Thematic Analysis of Responses to Question 6 (on Ceasing Sustenance)

Participants in this group overwhelmingly ($n = 77$) had no objection to the cessation of sustenance, and agreed or would be 'happy' to cease oral food and/or drinks in the final days of life provided no quality of life remained, or if it was no longer possible to eat or drink (e.g., *'I support this practice. If there is no quality of life and life is a struggle then allow death to proceed'*, *'... if the "patient/person" isn't able to eat or receive that support due to "organs" failing, then I don't see any reason to stopping the food or drink and allow the person to "pass" gracefully.'*)

- Some participants spoke specifically about not having an objection if it is medically recommended ($n = 28$): *'I would be guided by advice from the medical team. We have as a family journey through this process with parents and other family members.'* *'Only as recommended by my trusted medical advisers.'* *'If that is required medically. If I was unable to take food or drink then that would be how it is. It wouldn't be a deliberate way to end my life.'* *'I am willing to accept the view of medical professionals in this regard. I do not consider this euthanasia.'* *'While ever a person is able to eat and drink then they should be fed but if it is detrimental to their life then I would be guided by doctors etc.'*
- Some specified their agreement as conditional upon a person's inability to consume food or liquids ($n = 27$): *'[D]epends on the state I am in. If I am going to die anyway, I would be fine with it.'* *'Only if the person can no longer sustain this.'* *'Only give what the body is able to take/process/digest naturally. If body unable do these functions by itself—with little assistance in the actual feeding then there is no issue to cease food.'* *'If you are able to get by yourself and suffer no harm, eat on. However, if by the above you mean to starve yourself, no. If however you are again in a coma, and being fed intravenously—and you are being prolonged from end "yes".'*

Responses that hinged on the expertise of medical professionals may be construed as an abdication of agency to a 'medicalized' milieu, or may indicate conditional deference to the authority of knowledge embodied by another. These alternatives may be a fruitful subject of future enquiry. Even so, the responses overall give evidence of distributed capacity to distinguish foresight and intention. They also regard autonomy as in some sense subservient to capacity: food and drink continue to be received as life-giving gifts, until such time as the body is unable to make them so. Since the majority of respondents were educated to a secondary level we know that any tertiary study of moral philosophy was certainly in the minority, and probably in a small minority; yet it is interesting to see how fluidly and fluently their capacity for moral deliberation proceeds.

On the other hand, objectors took the subject of the participle 'ceasing' to refer to carers, and focused rather upon the obligations of care within an intimate community of carers. These responses are formally grouped as 'objections' ($n = 28$):

- Some construed the question as supposing a form of inhumanity: *'Starve someone ... not in favour of this.'* *'Not on—this to me is a form of torture and adding additional pain to the person.'* *'Completely inhumane and like killing a person—denying the things needed.'* *'Although this is a standard practice I consider it crude form of euthanasia. A cruel way to kill someone where both the person and their family suffer.'* *'I think this is absolutely wrong !! Loved ones want water or ice should be able to have this rather than starve to death.'* *'I do not believe that denial of normal sustenance should be practised if the patient is viably interactive. If there was one thing that I found distressing, in my wife's treatment, was the removal of intravenous fluid and oxygen. It is my contention that these two basic elements coupled with freedom from pain work in harmony to provide maximum comfort for the personal approaching death and are unlikely to extend the length of their life.'*

Therefore although formally grouped thematically as ‘objections’, materially these responses amplify the moral reasoning of those in agreement. They indicate a robust contention that care should not be regarded as a ‘burden’ upon carers, and that the provision of bodily care, where indicated, remains incumbent upon carers as their primary moral responsibility. We see, then, a positive conception of care and of its receipt.

A large number of respondents ($n = 46$) used the question to alert the researchers to further considerations that should be taken into account.

- Comfort was mentioned frequently, particularly in reference to oral hygiene and mouth comfort: *‘I would like to be kept comfortable—keep me as nourished as you can.’ ‘If I am able to take them in limited amounts and that is comforting.’ ‘If a person can manage these I think some should be given but if they cannot I would like that the mouth area is hydrated and not left to dry out.’ ‘Suitable, attractive food and drinks should be offered, and something available at any time if asked for by the dying. The Dying should be able to decline food and / or drink. Definitely not forced to eat something. Drinks, even a little, should be encouraged to ease suffering.’ ‘It is more important to keep up some fluids or thickened fluids than food. To not have a very dry mouth or sense of thirst would be good. I would not force a person to eat who found it difficult or simply did not want to.’ ‘I would not want to be deprived of drink if I am thirsty, even if there is risk choking. I have been with people in their last hours when thirst becomes intense and longing for water far outweighs any other pain / discomfort or fear of hastening death. If the desire for food or drink is not present I don’t have a problem with ceasing them.’ ‘Depends if the patient has capacity to ask for food and drink. Depends if the patient will experience distress or additional discomfort as a result.’ (One participant objected personally in response to the question, but added: ‘Not fine, but respect others’ informed choice’.)*
- Equally, forms of empathic attunement—often couched in terms of ‘respect’ ($n = 22$)—were amply evidenced: *‘What did the patient want? Yes by all means.’ ‘If I don’t want to eat or drink then I think my wishes should be considered. Conversely, if I want to eat or drink then I should be able to do that too. I wouldn’t like to think that I would be denied food/drink just because someone thought I was dying. I simply want the right to choose (if I’m able to) what I want at that time.’ ‘Food and/or drink should not be denied or forced. Who can give a definitive answer to this—there shouldn’t be a “blanket rule” (one size fits all). I would want to be treated on an individual basis.’*
- Four instances of reference to spirituality were governed by a similar ‘theologic’ as espoused in Question 5: *‘Each day is in God’s hands. I trust Him and others to guide me to naturally live. My time is in The Lord’s Hands!’ ‘The Bible tells us that God has numbered our days on this Earth, therefore I would not do anything to bring about my own ending. I believe I am in the hand of God.’*
- About a tenth of all respondents ($n = 26$) articulated no view or no understanding of the issue: *‘I have no understanding of this aspect. I would choose to live as normally as possible in my final days, including eating, but probably to a lesser extent. If this is a problem to nursing staff or undertakers, I’ll understand!’ ‘I have*

no view on this matter. If I asked for this then I would expect this to be accepted. Should there be laws to enforce people to eat at the end of their life? Only if they are in institutional care then all monetary government support should be withdrawn forthwith, as this is a sign of non caring support!’ ‘I’m not sure about this—I haven’t observed this in anyone so don’t feel qualified to answer.’ ‘I’m not sure about this question. I would need to be more informed on the purpose of it and if it caused any suffering.’

- Finally, some responses simply observed the phenomenology of individuals ceasing their intake of food and drink, and stopped short of overt moral evaluation: *‘Saw how my mother hated food at the end. She said it tasted “rotten” love.’ ‘Saw my sister & brother-in-law not eat in final days. Was very upsetting to think hunger may have been an issue but hopefully doctors knew what they were doing.’*

Although there is no neat way to summarise this miscellany of responses, they highlight various aspects of serious moral deliberation. On the one hand, the first set of knowledgeable responses seem influenced by experiences of giving care, or of witnessing such care at close quarters. On the other hand, responses that reserve judgment postpone taking a definitive stance in the absence of such knowledge. In both cases, then, moral reasoning is predicated on the bodily *esse* of dying. Those indicating empathic attunement disclose it as a fundamental moral datum. Conversely, the responses indicating an absence of analogous experience, or recounting morally serious anecdotes without immediately generating a moral ‘principle’, may be regarded as forms of epistemic humility. The spiritual responses connote the immanent presence of a divine agency supervening human agency, and so relativize the ‘weight’ of human agency. All responses arguably represent an ‘ethics of everyday life’ that is easily missed in more ‘elevated’ moral discourses.

The Proposal

We will return to the significance of this study by way of the proposal of Anglican ethicist Michael Banner, who queries existing discourse constraints upon moral philosophy, asking why they must dictate terms to moral theology and what might be an alternative.¹³ The occasion of his questioning was the dénouement of the Alder Hey scandal, where a UK government enquiry into a Liverpool children’s hospital of the same name found that hundreds of tissue specimens of deceased children had been retained by the hospital without parental knowledge or consent. The enquiry ordered the return of this tissue to the parents. What happened next piqued Banner’s interest.

Even while the enquiry continued and the material was being returned, agents of the hospital *chose to retain a subset* of the material, again without parental knowledge and consent. What is more, according both to anecdotal evidence and professional discourse around the parents’ now amplified outrage, it became evident that thought-leaders in the medical establishment were unable to find any intelligible moral reasons for the parents’

13. See Banner, *Everyday Life*, *passim* and especially his concluding Chapter 8.

outrage. Says Banner, ‘to very many of these actors and commentators, the parental wishes were evidence of mere confusion, error, sentimentality, or emotionalism; they had to be reckoned with or managed, to be sure, but they couldn’t be understood and didn’t need to be genuinely respected.’¹⁴

This kind of incomprehension suggests to Banner that the modern discipline of ‘bioethics’ (and, by extension, the analytical form of moral philosophy that is its wellspring) has been tried and found wanting if it could not illuminate so basic a parental response. As he puts it, ‘Why did bioethics not only fail to provide any means of comprehension, but actually very often took on the task of justifying the professional disdain?’¹⁵ We might respond to Banner’s query by observing that here is laid bare a form of ‘mind-blindness’ bearing more than passing resemblance to positivist conceits that declared whole classes of utterance as ‘nonsense’; and that although this school is long-defunct, some bioethical habits of mind retain its imprint.

Banner goes on to point out that if the moral frame of ‘bioethics’ is so myopic, it can hardly be expected to serve as a useful dialogue partner for moral theology, even though much Christian discourse in the ethics of life and death takes for its departure point the rules of that game. Banner proposes instead that moral theology should engage the discipline of social anthropology, given that discipline’s expertise in mapping and articulating webs of meaning in various communities. More specifically, what makes people tick ethically ‘will only be noticed and understood by the patient ethnographic enquirer’,¹⁶ for rather than being a domain susceptible to the sceptical tradition of analytical philosophy, ‘morality exists as a practice of such a kind that if the meaning, logic, sense, or significance of morality is to be fathomed, it will be fathomed by the sort of approach and manner of investigation characteristic of anthropology’s ethnographic method’.¹⁷

Engaging with the responses of 270 people from a particular expression of Christian faith is manifestly an instance of such enquiry. The survey results offer an *emic* (insider’s) perspective on the nature of their moral reasoning and experience. Given the selection pool (older Salvation Army officers), the moral structurings of the respondents has provenance within a Christian theological account of life and death. It is a fair guess that most of them are thoughtful practitioners of Christian ministry who have integrated their observations, their theology and their existence over time. In their own way, they are moral theologians, and so represent a body of thought and practice that is eminently susceptible to ethnographic enquiry.

A study by Andrea Rodríguez-Prat and Evert van Leeuwen¹⁸ also exemplifies such ‘patient ethnographic enquiry’. The authors characterise their study as a work of ‘meta-ethnography’, so named because it attends to 14 other ethnographic studies with a total

14. Banner, *Everyday Life*, p. 199.

15. Banner, *Everyday Life*, p. 199.

16. Banner, *Everyday Life*, p. 202.

17. Banner, *Everyday Life*, p. 201.

18. Andrea Rodríguez-Prat and Evert van Leeuwen, ‘Assumptions and Moral Understanding of the Wish to Hasten Death: A Philosophical Review of Qualitative Studies’, *Medicine, Health Care and Philosophy* 21.1 (2018), pp. 63–75; online: <https://link.springer.com/article/10.1007%2Fs11019-017-9785-y>.

sample size of 280 participants from around the world, including patients, families and healthcare professionals.¹⁹ These 14 studies all examined the wish to hasten death. The qualitative data warrant the authors' inductive distillation and synthesis, in which they successfully exhume several respondent assumptions. Patients' and carers' wishes to hasten death assume various moral understandings of dignity, autonomy and authenticity. Their wishes to hasten death also assume various moral understandings of social interactions, including perceptions of how others assign value to the sick individual, and of what constitutes a 'worthy' life'. These are all affected, in turn, by the overarching context of 'medicalisation'.²⁰

The meta-study is not strictly commensurate with the findings of the Salvation Army officer survey either in method, sampling or communities represented. But a broad comparison of them hints at what is obvious since at least the later Wittgenstein: that the forms of life embedded within various communities, the assumptions undergirding them, the practices sustaining them, and the thoughts and affections from which they spring, are primary to moral enquiry rather than some epiphenomenal postscript to it.

The Interlocutor

The problem Banner opposes and what rides on opposing it are neatly illustrated in a recent statement by Peter Singer. The statement illustrates a chain of deduction that opines on the end of life while simultaneously rendering invisible the moral experience of anyone outside Singer's own frame of reference, so enacting the kind of 'mind-blindness' asserted above.

As is well-known, Singer's preference utilitarianism sets a high but not absolute value upon personal autonomy. Expressions of personal autonomy must be set within whatever considerations for social utility prevail at the time; and where no capacity to express personal autonomy is evidenced, the supposed demands of social utility prevail. He has held to a consistent position on the ethics of the end of life at least since his 1994 *Rethinking Life and Death*²¹ where he believes that 'the sanctity of life' constitutes the main, or even the only, religious precept with enough deontic traction to oppose his own preference utilitarianism. In this work, Singer sets about eroding the conceptual legitimacy of 'the sanctity of life' for moral reasoning. Part of this project includes the attempted dissolution of the pivotal distinction within 'double-effect', by objection to any account of morality that holds us 'responsible for what we intentionally do in a way that we are not responsible for what we deliberately fail to prevent'.²²

His moral position on dying has been crisply articulated in a recent volume of short essays.²³ For Singer, the only relevant moral considerations at the end of life are the

19. Rodríguez-Prat and van Leeuwen, 'Assumptions', p. 64.

20. Rodríguez-Prat and van Leeuwen, 'Assumptions', *passim*.

21. Peter Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics* (Melbourne: Text Publishing, 1994).

22. Singer, *Rethinking*, p. 221.

23. Peter Singer, *Ethics in the Real World: 82 Brief Essays on Things That Matter* (Princeton, NJ: Princeton University Press, 2016).

dying person's quality of life—measured largely according to their capacities and their suffering—and their choices arising from that experience. (This triad of capacity, suffering and choice arguably distills the historic philosophical contributions of Locke, Hume and Kant respectively.) Another relevant moral consideration for Singer is collective. Singer repeatedly issues limits upon the obligations of taxpayers toward those who choose—or whose families choose—to 'prolong' life by medical means.²⁴

In an essay challenging the use of antibiotics for patients with advanced dementia, his triadic moral calculus of capacity, suffering and choice, and the constraint upon choice implied by the collective, is very simple:

[H]ow many people want their lives to be prolonged if they are incontinent, need to be fed by others, can no longer walk, and their mental capacities have irreversibly deteriorated so that they can neither speak nor recognise their children? The interests of patients should come first, and I doubt that longer life was in the interests of these patients. Moreover, when there is no way of finding out what the patient wants, and it is very doubtful that continued treatment is in the interest of the patient, it is reasonable to take account of other factors, including the views of the family, and the cost to the community.²⁵

On the face of it, the essay is a subset of legitimate moral consideration of what might constitute 'burdensome' treatment when we have no conceivable way to restore a person to health. It is also part of a wider public policy debate about the dis-utility for the collective entailed by the overuse of antibiotics.

But despite the legitimacy of both those enquiries, a sleight-of-hand is at work since in this case, the treatment (antibiotics) is not necessarily burdensome. Rather, life itself (in Singer's estimate) has become so. There are other problems with the paragraph. Singer does not pause to consider whether there may be a moral obligation upon carers to prevent the very considerable suffering caused by sepsis when we are able to do so—a suffering that is all too likely when the person with dementia cannot report it. Singer's reasoning seems also to presume that only a person's wishes in the present count as morally relevant; and these being inexpressible, Singer presumes them basically to be the same as would be his own. No consideration is made of whether or not a person's previous expressions count—as, for example, in an 'advance decision', a diary, or even a survey response—thereby asserting a total bifurcation of the person in dementia from what Singer construes as the former, 'real' self.

But what we really must observe in this paragraph is the monolithic nature of Singer's moral diagnosis: that the diminution of capacities translates straightforwardly into a life that is against these people's interests; the way Singer's own 'I doubt that' translates—without any self-doubt about his doubts—very straightforwardly into the more objective-sounding 'very doubtful that'; and that by the end of the paragraph, the interests of family and community take precedence. A highly disturbing *fait accompli* besets this

24. See, for example, the final sentence of his 'Beyond the Ethic of the Sanctity of Life', in *Ethics in the Real World*, p. 88.

25. Singer, *Ethics in the Real World*, pp. 85–86.

thinker's reasoning, despite the undoubted self-evidence of it to him. His line of thought is, at a minimum, an *etic* (outsider's) account of the life of these people with dementia who for Singer are inevitably insensate and devoid of 'interests' in the treatment of their infection. A dubious chain of deduction finally lands on a highly prescriptive account of the end of life, all the while obscuring any alternative possible moral accounts of actual moral subjects.

Singer's indubitable assertions about other people's lives seem blankly unable to imagine other possibilities in the minds of others. An ethic benchmarked on the fulfilment of conscious preferences, as conditioned by the good of the collective, arguably enacts a kind of 'mind-blindness' about the past-expressed and now-hidden mind of the dying. We may fruitfully observe in passing that here is precisely the kind of reasoning that Christine Bryden vigorously contests from an insider's perspective. Christine has been diagnosed with advanced onset dementia since 1995. In 2017, she was awarded a doctorate at Charles Sturt University for her autoethnographic enquiry into her experience of herself as a sufferer of dementia, in which she contests accounts of herself such as those Singer assumes.²⁶ Oddly too, Singer's approach to dying humans seems quite at odds with his highly imaginative, nuanced, generous and very compelling arguments about the inner lives of animals.

Sentiments like these have for many decades set the terms of public engagement for discussions around end-of-life care. A stunning example emerged from a 2009 Australian *Newspoll* telephone poll finding that 85% of Australians were in favour of voluntary euthanasia. It was later revealed, however, that respondents had been asked a single question, with interviewers explicitly instructed to include the emphases indicated: 'If a hopelessly ill patient, experiencing *unrelievable* suffering, with absolutely *no* chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose, or not?'²⁷ Suffice to say that the question is a little loaded in the direction of a particular fear-inspired narrative ('hopelessly', '*unrelievable*', 'absolutely *no* chance') and takes no account of other options available to such a person, certainly in relation to palliation, and patently excluding the mechanisms of hope experienced by many of our 270 respondents. Banner's point, in essence, is that moral theology needs not take such narratives as its terms of reference, whether stated in the bowdlerised terms of the *Newspoll* survey or in Singer's sonorous tones.

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26. Christine Bryden, 'Challenging the Discourses of Loss: A Continuing Sense of Self within the Lived Experience of Dementia' (Doctorial thesis, Charles Sturt University, 2017); online: <https://researchoutput.csu.edu.au/en/publications/challenging-the-discourses-of-loss-a-continuing-sense-of-self-wit> (accessed 13 March 2018). The most convenient overview of Christine's written corpus can be found at her website, www.christinebryden.com.
27. Newspoll, 'Euthanasia Study: Job No. 091005' (Surry Hills, NSW: Newspoll, 2009); online: https://cdn.theconversation.com/static_files/files/5/76079-2017-04-24-polling-091005_Euthanasia_Study.pdf (accessed 1 March 2019). See further Andrew Cameron, 'Euthanasia Question Needs Wider Discussion', *Sydney Morning Herald*, 8 October 2009; online: <https://www.smh.com.au/politics/federal/euthanasia-question-needs-wider-discussion-20101007-169kx.html> (accessed 1 March 2019).

Implications for Ethical Inquiry and for Moral Theology

End-of-life care is a perennial issue for every society, probably in every age. But in our own time, a vast literature now connotes to the average person and her carer(s) the need for a highly technical knowledge of medicine and bioethics in order to proceed. The matter has increasingly become framed in terms of the emotional and economic costs to all involved; control of the parameters supposed to constitute a 'good' death; uncertainties around where life ends and death begins; a largely unconsidered 'passophobia' (to coin a neologism around the typical Western horror of suffering); and whether interventions are excessive or the lack of them negligent. In this milieu, advocates for legal voluntary euthanasia and physician-assisted suicide highlight the terror of incapacity and pain, the shame of becoming a 'burden', and the *sine qua non* of personal choice in every condition of our fading life.

These complexities threaten to rob us of the validity of our wisdom, and beckon us to surrender to others the task of moral reflection upon our impending death. Within this milieu, arguably less obvious are the considered moral reflections of those who wish for no intentional shortening of life, and who do not regard their being cared for as an illicit imposition upon others. Their reasons to be sanguine about the precise mode of their dying can become opaque to medical professionals.

The results of the Salvation Army officer survey showcase the everyday moral reasoning of a particular group of older people, most of whom exemplify what has become a less obvious approach to death. At an absolute minimum, its value lies in meeting the researchers' intent to guide the care of these people and those like them. The rich weave of their moral universe, their highly textured ability to read the signs of their situation, and their life-long practices inhabiting what they believe, should be the central datum of moral deliberation for moral philosophers and government policy makers alike. Even the most ardent secularist or atheist should be able to concede that within a liberal polity, any healthcare setting absent of spiritual care for such people is at least incompetent, and more likely, mundanely abusive.

It does not follow that moral theology should bow before this data, since forms of moral theology have generated it. Rather, moral theology has a role to articulate its 'theologic' to give back to a community like the Salvation Army for their ongoing consideration. Indeed for many respondents, *only* moral theology could serve as the natural and most satisfying dialogue partner to articulate and elucidate their accounts of the dying person's moral agency.

Moral theology's task is also to present its position without demur as a fact of life, and a form of life, in the world. According to Banner's proposal, it would be meaningful simply to read and reflect upon these survey responses without further note or comment as descriptive of the norms of 270 people who represent many others. At the least, that minds and hearts exist in the world who inhabit this approach to death is also a primary moral datum.

But we can say more.

Firstly: it is not obvious that the respondents' moral reasoning is susceptible to charges of 'confusion, error, sentimentality, or emotionalism'.²⁸ Equally, nearly a quarter-century

28. Banner, *Everyday Life*, p. 199.

after Singer proclaimed ‘the collapse of our traditional ethics’ (the subtitle of *Rethinking*), its ongoing existence in actual lives demands respectful attention and accounting. Singer’s case is further compromised when we found no instance of the ‘sanctity of life’ as the overt deontic driver of respondents’ moral deliberation. Yet the kind of moral reasoning on view in the Salvation Army officers effectively replies to his own account of the end of life.

Second: it is instructive to note an almost complete absence of the wish to hasten death among these responses. This absence might fruitfully be compared to the moral reasoning of those who wish to hasten death in the Rodríguez-Prat and van Leeuwen studies (that wish being the authors’ criterion for respondent selection). If we may infer some level of anxiety in the wish to hasten death, we may also wonder what gave our respondents a comparative lack of anxiety when confronted with the same issues. Of course, that our respondents were not currently dying makes any comparison provisional and tenuous. Yet *prima facie* the existence of this contrast, and its possible reasons, may be the subject of further ‘patient ethnographic study’.

Third: our respondents were as aware of conceptions of ‘dignity’ as those who wished to hasten death in Rodríguez-Prat and van Leeuwen, but without regarding hastened death as the means to uphold dignity. They implicitly disagreed with assumptions within the discourse of ‘dying with dignity’, where ‘dignity’ is supposed to consist, effectively, in the ending of care. Also implicitly, they hotly opposed the speciously-named discourse of ‘assisted dying’, where ‘assistance’ consists in the abandonment of the person in need of care, since the ‘assistance’ in ‘assisted dying’ actually refers to the withdrawal of the assistance we once called ‘care’. (The withdrawal of *care* must be carefully distinguished from the withdrawal of *burdensome treatment*, which is often supplanted by better forms of care.)

Fourth: our respondents were also aware of the importance of autonomy, but largely without a ‘narrative of self-determination [that] could often be observed among those patients who, faced with the end of life, expressed a strong desire to take control of their circumstances and the process of their illness’ in Rodríguez-Prat and van Leeuwen’s findings.²⁹ Our respondents’ comments about God’s agency highlight this difference.

Fifth: for a combination of factors (notably, relationship with God and the presence of an intimate community of carers), our respondents seemed easily able to envisage the final days of their lives as retaining meaning. Rodríguez-Prat and van Leeuwen observe that:

A topic of recent debate in the clinical context has been whether ‘meaning in life’ may serve a protective role (psychologically) in patients with advanced disease, and there is evidence to suggest that those individuals who express a [wish to hasten death] experience a loss of meaning in life. In our analysis of patient statements we observed that a loss of life’s value or meaning was the result of suffering for which there was no hope of a cure.³⁰

In contrast, and even though Questions 5 and 6 in the survey instrument were not explicitly testing for respondents’ conceptions of ‘meaning’, it is instructive that respondents

29. Rodríguez-Prat and van Leeuwen, ‘Assumptions’, p. 73.

30. Rodríguez-Prat and van Leeuwen, ‘Assumptions’, pp. 73–74.

did not allude to an onset of meaninglessness at the end of life. Again, the reasons for this contrast deserve further study, if only to inform the somewhat desperate and melancholic tenor for healthcare settings apparent in Rodríguez-Prat and van Leeuwen's findings (acknowledging, of course, their deliberate selection bias).

Finally: our respondents were broadly aware of medical authority. While they were to some extent aware of the negative aspects of 'medicalisation' found by Rodríguez-Prat and van Leeuwen ('such as ... the depersonalisation of death in the hospital context, or the use of drugs that prevent a person from being aware of the end of life'³¹), our respondents were arguably less fearful of it. We do not really have enough data here to conclude that Christian moral theology is protective against loss of meaning at the end of life and against the deleterious aspects of 'medicalisation'. But we have found *prima facie* evidence for a hypothesis along these lines that would require further ethnographic testing.

A follow-on matter may then become the extent to and respects in which moral theology may lay claim to indicating definitive, objective norms for human flourishing, an age-old question for Christian apologists and their detractors alike. Suffice to say that in the terms of this article, that discussion is a separate consideration.

Appendix A

Survey instrument

These questions were used in the survey:

End-of-life Care: *The following questions ask for your thoughts about aspects of end-of-life care. There are no right or wrong answers to these questions; rather we are interested in your views on this topic. You can write your thoughts in the box provided below each question.*

1. *What relationships do you consider important to you in your end-of-life care?*
2. *How do you see these relationships being supported at this time?*
3. *What do you think your most important emotional needs during your end-of-life care will be?*
4. *How do you see these needs best being met?*
5. *What is your view on using pain medication during your end-of-life care knowing whilst relieving suffering and pain this may also hasten death?*
6. *What is your view on ceasing oral food and/or drinks in the final days of life?*
7. *Can you describe what for you would be your desired end-of-life experience?*
8. *What expectations do you have of chaplaincy services in end-of-life care?*
9. *How would you like to express your spirituality at the end of your life?*

(The final two questions asked for feedback on the survey instrument, and invited further research participation.)

31. Rodríguez-Prat and van Leeuwen, 'Assumptions', p. 71.

Participants

The participants were working and retired Salvation Army officers from the Australian Eastern Territory (N = 270). The age range was 30 to 93 years (M = 66.88; SD = 13.93) with 153 males and 102 females (15 participants did not report gender). In terms of relationship status: over 70% of the sample were married, 11% single, 12.5% widowed, 2.7% divorced and 2.4% separated. Most of the participants had a secondary-level education (52.9%), 41.3% had completed a university bachelor or postgraduate degree, and 3.9% had completed primary school only.

Materials

The survey sought demographic information including age, gender, marital status and level of education as well as a 'further comments' box. The purpose of this box was to allow participants to comment on the survey or the research in general. Respondents filled out measures of quality of life (QoL) using the WHOQOL-BREF.³² Religious and spiritual QoL was measured using the WHOQOL-SRPB.³³ The results of these measures were analysed in a separate quantitative paper.

Procedure

The research proposal was approved by the Charles Sturt University ethics committee. A survey was sent by email to current and retired Salvation Army officers in Australia's Eastern Territory, an administrative region of the Salvation Army in Australia. There was an option to complete an online or paper version of the survey. Some chose to complete the paper version which was returned to the Salvation Army for entry into the data file. No identifying information was included with the surveys. An inductive thematic analysis of content, using the software package NVivo 11.4.0, was conducted on the data.

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32. World Health Organization Division of Mental Health, *WHOQOL-BREF: Introduction, Administration, Scoring and Generic Version of the Assessment: Field Trial Version* (Geneva: World Health Organization, 1996); online: <http://apps.who.int/iris/handle/10665/63529> (accessed 13 March 2018).
 33. World Health Organization, 'WHOQOL Spirituality, Religiousness and Personal Beliefs (SRPB) Field-test Instrument' (Geneva: World Health Organization, 2002); online: <http://www.who.int/iris/handle/10665/77777>, www.who.int/iris/handle/10665/77778 (accessed 13 March 2018).