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Medicine's Eschatological Narrative and the Challenge of Elder Suffering

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Medicine's Eschatological Narrative
and the Challenge of Elder Suffering

by

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Dissertation

Presented to the Faculty of the Graduate School of
The University of Texas Medical Branch
in Partial Fulfillment
of the Requirements
for the Degree of

Doctor of Philosophy

The University of Texas Medical Branch
May 2015

Acknowledgments

If it takes a village to raise a child, then surely it takes an island to raise a doctoral student. I am humbled and profoundly grateful to the many people who helped me mature into adulthood and cultivate the virtues of a scholar. Without their support, guidance, assistance, and encouragement, I would not have been able to complete this dissertation.

First and foremost, I thank the four dissertation advisors who have mentored, challenged, and supported me. I began this dissertation under the mentorship of Dr. Harold Vanderpool. His formidable intellect and exceptional teaching skills inspired me to plunge deeper into my scholarship on suffering and the religious features of modern medicine. Dr. Jan Heller pushed me to think more critically about eschatologies and this eschatological narrative that so captured my attention. Dr. Mark Clark encouraged me to think about the stories that could be used to revise the eschatological narrative. Dr. Anne Hudson Jones, always a mentor, guided me to the finish line. Her wisdom, discernment, and honesty meant the difference between stagnation and completion of this work.

I am also grateful for the assistance and guidance of the members of my dissertation committee. Drs. Michele Carter, Thomas Cole, and Lee Grumbles spent their time—that precious resource—meeting with me multiple times. They are all excellent teachers, and their patience with their student was appreciated. I thank them for their difficult but fair questions as well as their comments and criticisms. Their insights made my dissertation a more rigorous and clearer work. Dr. Cheryl Vaiani stepped in before my defense to sit on my committee. I thank her for sharing her talents and experience as an educator with me.

I have had the great privilege of working with the faculty of the Institute for the Medical Humanities. They have shown me the value of reflection, the importance of

dialogue, and the power of interdisciplinary thought. An education can never be taken away, and I shall be forever in the debt of the professors who taught me what it means to be a medical humanist.

Dr. Michael and Maggie Fuller, and Colleen Casey, have been a tremendous source of joy and support on the island. The Fullers and Colleen exemplify the best part about what a small community can offer. When the challenges of graduate school became overwhelming, they were always just next door with a glass of wine, laughs, and a backyard filled with rowdy chickens and inspiring art. They have always made me feel utterly welcome in Galveston, hosting my thirtieth birthday party and giving me my beloved pet, Lulu, who has supported me in her unconditional, steadfast doggy way.

Drs. Dorian and Anne Coppenhaver have been true mentors to me. Dr. Dorian Coppenhaver's invitation to lead the Committee for Career Development helped me grow in my leadership skills. His support and advice kept me moving forward when I felt like my research was at a standstill, and I will always appreciate his distinctive talent of blending gentle humor with hard advice. Dr. Anne Coppenhaver has been a generous friend, sharing her own stories and advice about graduate school and providing much needed encouragement and wisdom about the path of academia.

I extend heartfelt thanks to Donna Vickers. Her organization, patience, and dedication to the graduate students are unparalleled. I also thank my fellow graduate students. They, too, have been important teachers to me. I have enjoyed our potluck suppers, late-night writing sessions, and, mostly, countless conversations about the role, nature, and future of the medical humanities. We have often marveled at our luck that we will get to spend our careers as professional colleagues. Rather than being competitors, the IMH graduate students have been fine interlocutors, engagers of *sermo*, and fellow journeymen as we have travelled through school.

I am most grateful for those closest to me personally. My mother, Kathy Kutac, my late father, James Kutac, my brother, Joshua Kutac, my friends Ahmar Hashmi, Dr.

Glenn Shuck and Daniel Underwood, my troop of strong female friends, Brittany Conley, Colleen and Elery Lesher, Casey Radle, Lisa Sells, Dr. Vanessa Slots, Kristin Thornborrow, Kristen Wakashige, and my companion, Dr. Caleb Davis, have witnessed first-hand the immense difficulties of undertaking a doctoral education. Their limitless compassion helped me through bleak years, and I could never fully thank them for the sacrifices they made to help me fulfill my potential. I can only hope to love them as well as they have loved me.

Medicine's Eschatological Narrative
and the Challenge of Elder Suffering

Publication No._____

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The University of Texas Medical Branch, 2015

Supervisor: Dr. Anne Hudson Jones

Abstract: This dissertation uses texts and methods of the medical humanities to interrogate the troubled relationship between modern American medicine and the mystery of human suffering. Methods used include conceptual analysis, close reading and comparison of historical texts, and narrative interpretation. These methods connect seemingly discrete lines of inquiry to reveal hidden cultural assumptions that influence the biomedical enterprise, particularly with respect to the expectations that practitioners and patients have about medicine's functions, abilities, and goals. I argue that medicine's inability to respond to patient suffering is a feature of a broader myopia within the culture of medicine—namely, how medicine functions in religious ways. My focus led me to pay greatest attention to one particular religious feature—medicine's adoption of an eschatological narrative. This narrative works within medicine in such a way as to obfuscate the interpretive means available to practitioners. The hope encapsulated by the eschatological narrative is manifested through its promises of ever more sophisticated ways of controlling the body via technological advancement. The experience of suffering has little place within this exciting narrative; suffering is marginalized or silenced within the practitioner-patient encounter. Elders, whose bodies' natural decline most starkly challenges the narrative's promises, are also those whose suffering is often neglected. Elder suffering helps simultaneously teach about the challenge of suffering and the eschatological narrative's limits. After chronicling the narrative's historical development,

I demonstrate how the humanist project is particularly suited for developing ways of engaging with elder suffering. The medical humanities give means for cultivating habits of being that resist the eschatological narrative's limiting nature. Studying and practicing the humanities can equip the practitioner with creative ways of engaging the breadth of humanity, its multiple sources of suffering, and the particular ways that aging can be experienced.

Preface

The historian Richard Waswo argues that the stories we tell about our origins are partly constitutive of identity.[1] My dissertation, in which I undertake an exploration of the relationship between modern medicine and elder suffering, developed as the culmination of my education at the Institute for the Medical Humanities (IMH) and as the end result of a ten-year investigation inspired by the experience of my grandmother and her peers at a long-term care community.

My grandmother was a strong, gentle woman. Diagnosed with Alzheimer's disease in 1997, she lived with the disease until June 2003; she died one month after I finished a master's degree studying Alzheimer's disease. She progressed through the illness in a textbook fashion, demonstrating all of the stereotypical symptoms of the disease: depression, hallucinations, wandering, disorientation to time and space, muscular constriction, the systematic forgetting of familiar people, and, eventually, the loss of the ability to take care of grooming, dressing, toileting and feeding herself.

During the early stages of the disease, I can safely say that my grandmother suffered. She had recently been widowed, and the grief that she experienced after my grandfather's death precipitated a progression of the Alzheimer's disease that had no doubt been incubating for years prior to her diagnosis. She told my mother, her only child, that she felt like she was losing her mind. She was extremely distressed about this fact. We tried to reorient her when she got confused and place visual cues that reminded

[1] Richard Waswo, "The History That Literature Makes," *New Literary History* 19, no. 3 (Spring 1988): 541-564.

her of objects. In those days, reorientation to the present was protocol. My grandmother forgot that my grandfather had died, and we would gently remind her that he had passed away. Over and over, we made her cry as if she had just heard the news. We finally stopped telling her the truth because we were tired of causing her anguish.

Like so many patients with Alzheimer's, my grandmother was prone to wander, and eventually living alone was dangerous and untenable. Concerned with providing her the best care that her budget could allow, my family and I shuttled my grandmother through various long-term care communities. When she wandered out of her assisted living community we moved her to a locked dementia-care community. When her new caregivers at that facility lost my grandmother (she wandered out of an unlocked area when she was supposed to be supervised and was found walking along U.S. Highway 59), the administrators evicted her, saying that her needs were more than they could provide. When my grandmother forgot how to walk, our family had to find yet another care community that accepted wheelchair-bound residents. In this community, my grandmother spent the remainder of her life, moved from the television to the dinner table, to bed, and back again—in a kind of endless loop, broken only by our periodic visits and trips to the hospital.

Her resilient body continued to live, but she needed medical care. She had frequent urinary tract infections and her Alzheimer's medications caused side effects that needed management. As the plaques and tangles associated with Alzheimer's disease took over more of her brain, she became prone to aspiration pneumonia and other bacterial infections that required antibiotics. Once she was primarily bed and chair bound, she developed a large bed sore that required wound care. These medical issues

were all treated, often reluctantly. As a family, we were afraid that she would be in pain, and many of her medical problems were easily manageable. What kind of quality of life did we offer my grandmother? Without the ability to communicate with her, we could not tell. When we visited her she seemed content.

On the other hand, her time in the hospital was not always ideal. One story in particular has stayed with me. My grandmother was in the hospital with a urinary tract infection. The physician came in to check on her; she was lying flat in the bed with the physician standing over her bed and my mother on the other side of the bed. The physician spoke not to my grandmother but to my mother. He listed all of the deficits that plagued my grandmother, as well as all the things she would never be able to do again. My mother felt uncomfortable with the doctor talking about my grandmother in the third person, even though she was in their presence. Sure enough, when my mother looked down, my grandmother had a terrified look and tears were streaming down her face. Though she could not speak anymore, she gave indication that she understood what the physician was saying. The moment was short-lived; in an ironic blessing, the disease let her forget that painful interaction.

As I watched and experienced my grandmother's decline, I studied the philosophy of religion at Rice University. I read Kant and Heidegger and was troubled by what they wrote as it related to my grandmother's illness. The philosophers seemed to locate moral obligation in a person's ability to think, or to consider her *beingness* as a being. They argue that the ability to consider ourselves as humans separates us from other creatures, sets us apart, and makes our relationships unique and reciprocal. Unfortunately, my sweet grandmother had lost her ability to remember herself. Perhaps she was not a

person anymore. Perhaps we owed her nothing. Perhaps we owed a death that would release her from the prison of the body.

My family and I would visit my grandmother as often as we could, usually once per week. In these moments, we entered into a liminal space, where we engaged in a process of remembering my grandmother, putting her identity back together; in this way, we connected with her through memory. We remembered the roles that constructed her identity: wife, mother, grandmother, aunt, schoolteacher, churchgoer, and friend. She was not known only by her role as patient, Alzheimer's victim, or demented invalid; she was Effie, our beloved family member. We knew her by her smell, the shape of her hands, her wrinkles, freckles, and age spots. We gazed upon her with love, and the philosophers' words about cognition seemed irrelevant and cruel. To elect not to treat her sores and infections—to let her die—might be an easy intellectual decision to those in the academy but nearly impossible when confronted by her face and our collective memory of her. Grappling with this dilemma, I wrote my master's thesis. In it, I worked to relocate moral obligation in the body, memory, and emotion, rather than cognition.

As I mentioned earlier, my grandmother had multiple housemates who also needed various kinds of assistance with their activities of daily living. Some spoke; others did not. I tried to attend to each of them when I visited—I worked to remember them, too, even though I did not know their stories. Connecting with them took imaginative work and a kind of seeing that involved a moral recognition of their intrinsic worth. Their lives seemed to me so meaningless. They sat for hours in front of the television, always parked in the same chairs. They were side by side in their chairs, but they were mostly quiet, even though not all were living with late stage dementia. No

matter what time of day I came, there they were, sitting there with droning game shows, soap operas, or infomercials going on in front of them. Did they suffer? What did it mean to suffer? I did not ask them, but those questions resonated with me as I began my time at the IMH.

My story at the IMH began with Drs. Chester R. Burns and Harold Y. Vanderpool, who recognized the interconnectedness of religion and medicine, as well as the multiple historical dynamics that shape and construct any given world-view. In his class and published papers, Dr. Burns showed me that health is a robust concept that had to do more with wholeness than simply the absence of disease. Other types of ease—social, mental, and spiritual—must also be satisfied for someone to be truly healthy.

Dr. Burns encouraged me to give my first academic presentation, one that turned out to be a seedling of this larger project on religious features of modern medicine. Dr. Vanderpool and I continued exploring those features in his Religion and Medicine course. He led me to think deeply about whether medicine could actually be called a religion. With Dr. Vanderpool, I also began to think about suffering in new ways. Rather than being wholly anathema to the concept of health, some forms of suffering could potentially have educative and strengthening qualities that transform the experience of suffering into one that can be borne and tolerated.

As I was exploring these ideas, Dr. Anne Hudson Jones was teaching me about the inherent *storiedness* of culture and how narratives shape the ways humans act in the world. She introduced me to a polyphony of narratives and voices. From Dr. Jones I learned about the literary construction of the illness experience, which showed me how those within medicine think with metaphors. She introduced me to talented writers—

both those who lived with illness and those who treated patients—who put their experiences on paper. She taught me the aesthetic, cultural, and ethical value of complex pieces of literature. I learned about the depth of meaning contained within the pages of plays, short stories, and novels.

Drs. Ronald A. Carson, Michele A. Carter, and Cheryl Ellis Vaiani helped me to think more deeply about the moral world. More than simply rules to follow or regulations with which to comply, the moral world involves a kind of *beingness*—an awareness and attunement to the needs of the other. Acting as a moral agent involves cultivating a kind of responsiveness that opens up an area in which authentic human and humane interactions can occur. With Dr. Carter, I examined the structure of this zone and considered how a medical humanist could be a sort of architect of the moral space, providing the kind of generous welcome that could invite the telling of stories, the articulation of difficult experiences, and the moral response that might, even in the absence of cure, lead to the kind of emotional or social health that occupied the mind of Dr. Burns.

Finally, I took my Humanism and the Humanities course with Drs. Jones and Mary Winkler near the end of my coursework. The course was transformative in the sense that I left with a new idea about how one could move, in a deliberate way, through the world as a humanist. Within Renaissance writings, I met a group of scholars who, like the early men and women on the hospital wards, were making a new way through a contingent world. Studying the figures of Petrarch, Vesalius, Machiavelli, Pico della Mirandola, and Erasmus gave me an intellectual lineage. The *studia humanitatis*, as a program of cultivation of knowledge as well as the self, gave me a sense of intellectual

belonging as well as a set of interlocutors who could teach me more about what it means to practice the humanities.

During two of the years at the IMH, I completed a National Institute of Aging predoctoral fellowship on minority aging. I was the only humanist among rigorous social scientists; as a result, I found that the experience was another one of liminality. I took social science classes in which I learned about population health among elders, longitudinal studies about healthy aging among minority groups. The language used in these classes was new to me; I learned about risk factors, ways that health-care practitioners could help an elder age in better ways. Less familiar with strict social science research, I remained an outsider. Rather than diving into the numbers, I listened for the stories that were told in class—stories that illuminated the numbers and that brought statistics to life. The stories were optimistic and hopeful about what better research could achieve. When I presented a narrative of Alzheimer's disease in class, the students were disappointed that the story was more realistic than optimistic. To me, it seemed they craved the numbers that could point to happy endings about medical success.

I attended the Gerontological Society of America conference that year and saw that language at a national scale. There was a driving rhetoric to their project. Describing the body led to controlling the body, and controlling the body led to better physical health.

All of these forces, guides, and mentors were present to me as I began to consider my research question: Why do those who practice the medical arts have such a hard time engaging with their patients' suffering, even as the alleviation of suffering is named as a

moral end of medicine? The answer, based upon my research, is twofold. First, the answer involves reckoning with the nature of suffering. Like the notion of health, suffering is a complicated concept, with physical, psychological, emotional, and spiritual components that interact and may or may not overlap. Suffering is personal to the one who experiences it. One person's suffering is not like another's; each person's sources of suffering are unique. A common trait of suffering, however, is that the experience of suffering involves feelings of meaninglessness and powerlessness over time, which makes the experience isolating and frightening. Questions emerge about the nature of goodness and the reality of evil within the world. These are questions with no easy answers, and thus the experience of suffering involves dealing with mystery and ambiguity. The one who might respond to the other's experience is also challenged as the suffering person's crisis of meaning threatens the perceived stability of the other. The crisis of meaning imposed by a person's suffering often has no easy response.

The second part of the answer is directly connected to the religious features of modern medicine. I argue that the culture of modern American medicine, broadly construed, shares functional similarities with religion. Both religion and medicine are afforded access to special knowledge not granted to lay persons, utilize symbols systems, and engage in hierarchical learning and transformative education. Physicians share similarities to priests, even if the work that physicians do remains in the secular realm. Because of its connection to the experience of suffering, I chose to focus my research on one particular religious feature of modern medicine: its adoption of what I call the *eschatological narrative*.

Eschatologies, in religious traditions, are studies of final things. Within popular culture, eschatological thinking is present in the American understanding of apocalyptic eschatology within evangelical Christianity—the interpretation of the Christian book of Revelation that imagines a time in which believers will be spirited away to heaven and nonbelievers will be left upon the earth to fight a thousand-year battle between good and evil. While this eschatology has gained traction among this group, other types of eschatologies exist. What eschatologies have in common is the sense that some part of the current world must be fundamentally negated and that a new kind of world could be made manifest. What so challenges the realm of medicine that it requires a negation of such force? Death and the suffering that accompanies the illness experience most powerfully challenge medicine.

I argue that medicine does not have a fully realized eschatology but has adopted a kind of eschatological narrative that has become part of medicine's social imaginary, the unstructured background that informs the ways that large groups of people imagine their shared existence and functions almost as common sense. The story was once explicit. At the end of the nineteenth and beginning of the twentieth centuries, doctors spoke to each other about their perceived future—a time when the vagrancies of the body would be mastered. They imagined a time in the not-so-distant future when the knife would not wound, because they would have eliminated the need for it, health would be attainable by all citizens, and suffering would be rendered obsolete. They imagine that though the time had not yet come, researchers and scientists were moving ever closer to the Elysium fields when death would be conquered. My research led me to examine issues of the *Journal of the American Medical Association* (*JAMA*). I chose this periodical because of

its lasting influence and its reflection of broad conversations in which physicians of the time were engaging. Within this influential medical journal I found numerous examples of physicians presenting their hopeful image of the future. These examples are presented in my third chapter. As I read through the articles, what emerged was a vision of each new specialty seeming to offer new promise about what the culture of medicine could achieve, if not then, then sometime soon in the future. The story smacked of hubris, but over the course of about thirty years, it became a kind of totalizing or, to borrow sociologist Arthur W. Frank's term, a *finalizing* narrative that influenced expectations of what technology could achieve.

As I read examples from various dates in the twentieth century, I noticed a shift in the ways that the future was being framed. The elderly body came to rest under the gaze of the physician and those engaged in the broad conversation about health, aging, and longevity came to be more cognizant of the futility of trying to master death. Despite this reticence, physicians still worked within the constraints of the eschatological narrative.

My fourth chapter examines how a new iteration of the narrative emerged. Elders most starkly reveal the limits of the eschatological narrative. Their bodies demonstrate the way that the story breaks down and that the hope promised within the story is exaggerated. The second version of the eschatological narrative imagines that even if death could not be mastered, then surely health could be maximized to such an extent that people would age well and then die a peaceful death. The experience of suffering still has no place within this eschatological story. Suffering need not dare the person with the hard questions of meaning—one need only look toward a better pharmaceutical or a more

powerful technology. These two versions of the eschatological narrative work in tandem with one another, each making the experience of suffering unthinkable.

The eschatological narrative is invoked out of good intentions. It gives the one who responds to suffering a story in which *something* can be done, even if that something is simply to direct the person toward a future in which the body could be better managed. The story minimizes a person's unique sources of suffering by reducing them to entities that can be described and controlled. Rather than facing the challenge of truly reckoning with the mysterious aspects of human suffering, the narrative helps shield the practitioner from crises of meaning. It also propels great advancements in research and technology, which legitimate the story and further its acceptance.

I call the eschatological narrative *finalizing* because it crowds out other types of stories that might provide alternative ways of making meaning out of the suffering. The eschatological narrative denies the power of death and the crisis of meaning that accompany suffering by, in the best case, medicalizing the experience of suffering—making it something that can be treated or controlled. In the worst case, suffering becomes interpreted as an experience outside the purview of medicine and not necessary for the achievement of health. A robust sense of health demands more of the practitioner.

How is the well-meaning practitioner to revise the eschatological narrative? The first step is in being able to recognize and articulate the eschatological narrative. The second step involves learning other stories that could offer different interpretations of suffering. In my fifth and sixth chapters, I affirm the role of the medical humanities as the means for teaching and cultivating morally expansive ways of being in the world through the reading of complex pieces of well-written literature. These stories can come to be

like exceptional companions, ones that accompany the practitioner and continue to teach throughout a lifetime. By engaging with stories that come from wisdom traditions, practitioners can observe—through engagement with the texts—different ways of tolerating ambiguity, generously recognizing the other, and engaging in more authentic and humane care.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCING MEDICINE'S ESCHATOLOGICAL NARRATIVE

There is no medicine like hope, no incentive so great, and no tonic so powerful as expectation of something better tomorrow.

—Orison Swett Marden[2]

This dissertation explores the hope and promises of medicine vis-à-vis the reality of human suffering. Given the spaces for sickness and frailty, suffering is particularly present within the world of medicine. I use the texts and methods of the medical humanities to interrogate the troubled relationship between modern medicine in the United States and the mystery of human suffering.[3] I examine American medicine's silent spaces—the habitation for suffering that medicine has constructed—and the faith offered to fill the void when practitioners cannot provide solace to their suffering patient. The religious studies scholar Jerry L. Walls writes that "faith is . . . essentially future directed, and its certainty hinges upon events we do not yet see."[4] I argue that modern American medicine has a faith—in itself and in what it can achieve in time. This faith shares essential aspects with religious faith in a supernatural entity, though the faith itself is secular.

Indeed, medicine functions in several ways like a religion, but these features go

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[2] Orison Swett Marden, *He Can Who Thinks He Can, and Other Papers on Success in Life* (New York, NY: T. Y. Crowell, 1908), 72.

[3] The methods used include conceptual analysis, the careful reading and comparison of primary and secondary historical texts, and narrative interpretation. These methods connect and integrate seemingly discrete lines of inquiry to reveal hidden cultural assumptions that motivate and influence the biomedical enterprise, particularly with respect to the expectations that practitioners and patients alike have about medicine's functions, abilities, and goals.

[4] Jerry L Walls, *The Oxford Handbook of Eschatology* (New York, NY: Oxford University Press, 2010), 5.

largely unrecognized. In this dissertation, I argue that medicine's inability to respond sensitively and thoroughly to patient suffering is the result of myopic self-scrutiny that prevents crucial insights as to the fundamentally religious role it has assumed. Modern American medicine has adopted the descriptive and explanatory methods of scientific inquiry.[5] In doing so, though, medicine has ignored or repressed its religious features, ambitions, and desires. These features are congruent with long-held aims of medicine, even though they go unacknowledged, and their presence has effects upon the doctor-patient relationship. My focus upon the connection between medicine, religion, and suffering has led me to pay greatest attention, in this dissertation, to one particular religious feature within medicine—medicine's adoption of what I call an *eschatological narrative*. I refer to this *story* as the eschatological narrative of medicine because it arises out of medicine's role, inherited from religious authority, to speak with culturally valorized influence on matters of mortality and on capacities to stave off death—sometimes misguided—and thus on human aspirations to immortality.

At the encouragement of American and British cultures, whose dominant intellectual authorities grew increasingly secularist through the nineteenth and twentieth centuries, medicine came to function in certain, specific ways *like* religion. In particular, medicine has borrowed and utilized a feature prominent within some religious traditions—namely, concepts of redemption and salvation. Scholars of religion articulate these ideas as *soteriological* and *eschatological* studies. In this project, I use these concepts from the study of religion to demonstrate how medicine's practitioners and theorists think in religious ways, and how these ways of thinking affect, in subtle and

[5] See, for example, Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (Oxford, UK: Oxford University Press, 2006).

even invisible ways, practitioners' ability to respond to their patients' suffering.

A *soteriology* is a way of conceptualizing salvation, and an *eschatology* is the vision and understanding of the final destiny of an individual, collection of people, or all of humanity.[6] Eschatologies are studies within religious traditions of *last things*, conceptualizing ends: the end of oppression, the end of the world as it is currently known, or the end of time itself. Cosmic in scope and ultimate in nature, eschatologies provide a community with a sense of internal logic and a particular way of understanding a history and trajectory for the future. They have temporal and teleological characteristics and are focused upon an end believed to happen sometime in the (near or distant) future.

In some scholarship the term *eschatology* has been linked to the term *apocalypse* or *apocalyptic*, but the substitution can cause confusion. John Dominic Crossan, a leading scholar in the study of the historical Jesus, has furthered the academic understanding of eschatology through his clarifications and analysis of terms as well as the conditions for the development of eschatologies. He characterizes an eschatology as an umbrella term; *apocalyptic* describes only one of the different modes. Put another way, Crossan classifies an eschatology as a "genus" term and the various modes as the eschatological "species." Though the mechanisms of the modes differ, each eschatological mode fundamentally negates the current world—that is, each makes the presumption that something is so fundamentally wrong with the world that a transcendental mandate requires a radical remedy that is "profoundly opposite" to the

[6] Benedict T. Viviano, "Eschatology and the Quest for the Historical Jesus," in Jerry L. Walls, *The Oxford Handboo1k of Eschatology* (Oxford, UK: Oxford University Press, 2010).

perceived problem.[7] This radical end could be interpreted as a literal end to space and time and an end to the physical earth in the hopes of realizing a kind of perfect earth in heaven. The end can also be interpreted as metaphorical: it can be the end of oppression, a radical freeing from domination in the hope of realizing a kind of heaven here on the earth.

Medicine has an internalized, loosely articulated, imagined narrative about its own end time; this story is what I call the eschatological narrative. The imagined end is a time when health will have been maximized for all citizens. It will be a time when the vagrancies of the body will have been described and controlled to such an extent that illness carries no threat, and death will have been neutralized. The notion of physical redemption by medicine has become strong enough to resemble a narrative that speaks authoritatively and with postured understanding upon the otherwise mysterious matters of suffering, death, life's meaning, and immortality. Though those within medicine would not call their end time a "heaven on earth," the narrative imagines a world that is like heaven, in the sense that it is free from the evil forces that oppose health, medicine's ultimate good.

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[7] The three eschatological modes that Crossan describes are *apocalyptic, ascetical,* and *ethical.* The modes can interact and overlap. *Apocalyptic eschatologies* negate the current world by looking to a future in which God restores justice. A particularly American understanding of an apocalyptic eschatology has developed within parts of the Evangelical Christian movement by believers who wait in hopeful expectation of a quite literal Rapture that will spirit away believers. For a detailed analysis of the Evangelical identity as it is shaped by the particular apocalyptic understanding of the New Testament Revelation eschatology, see Glenn W. Shuck's book, *Marks of the Beast:The Left Behind Novels and the Struggle for Evangelical Identity* (New York, NY: New York University Press, 2005).

Those who adopt *ascetical eschatologies* negate the current world by withdrawing from typical aspects of life. *Ethical eschatologies* negate the world through resistance and protestation of the unjust, discriminatory systems. In opposition to the future, unrealized eschatology of the apocalyptic, which hopes to summon the literal end of history, the ethical eschatology works to realize a new system order in *this* time by its response to injustice. Crossan argues that "ethicism is present wherever nonviolent resistance to structural evil appears in this world. And the courage for it derives from union with transcendental nonviolence." John Dominic Crossan, *The Birth of Christianity: Discovering What Happened in the Years Immediately after the Execution of Jesus* (New York, NY: HarperOne, 1999), 282-283.

In *Existentialism and the Human Emotions*, the philosopher Jean-Paul Sartre asserts that "man is the being whose project is to be God."[8] He goes on to say that "God, value and supreme end of transcendence represents [sic] the permanent limit in terms of which man makes known to him what he is. To be man means to reach toward being God. Or if you prefer, man fundamentally is the desire to be God." This desire is not conscious; rather, Sartre describes it as coming close to human "nature" or "essence." This desire, according to Sartre, is realized symbolically in the concrete desires expressed and understood consciously. In medicine, the fundamental, unconscious desire to be God or godlike becomes symbolically realized in the concrete desire to help the patient. The eschatological narrative is fostered out of a strong aspiration to altruism as well as an intense, even insistent, desire to control those aspects of life that cannot be neatly managed. The passionate desire for control comes in contact with the patient's (or the patient's loved ones') own desire to be healed or to have their suffering contained. The myriad technological achievements of biomedical research seem to confirm the placement of the desire: medicine can do so much for an ill person; surely this time, too, medicine can be of service to the sick, failing body. This conviction leads to the delusion that those practicing medicine *could* always control the circumstances of the body. The narrative, thus, supports the denial of one's own limitations as a human in favor of a more hopeful story that overreaches and promises too much.

Medicine's adoption of religious features, particularly its soteriological characteristics and the development of the eschatological narrative, helps those enmeshed within its practice to craft a response to medicine's greatest challenges of meaning.

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[8] Jean-Paul Sartre, *Existentialism and Human Emotions*, trans. Hazel E. Barnes (New York, NY: Citadel Press, 1985), 63.

Religious eschatologies negate aspects of the world that threaten believers; the believers look toward a future with hope and take actions to help usher in their improvements. Sickness, suffering, frailty, and death all threaten practitioners' goals of restoring health and prolonging life; these phenomena threaten patients with the undoing of physical health and the potentiality of life. The redemptive eschatological narrative helps shield both practitioners and patients from the terror inherent in being a creature who can contemplate future nonexistence—a terror that becomes more acute when one believes that he or she may be dying *imminently*. In a world where bad things happen to good people, the righteous suffer and the corrupt prosper, eschatological faith "dares," as Walls describes, "to believe that our world finally makes sense, that life is fully meaningful."[9] In other words, eschatologies try to answer the questions: For what are humans allowed to hope? and What are the reasons for hope?[10]

Technologies and the therapeutic uses of them represent a fundamental promise and source of hope for vulnerable patients. The promises are often delivered upon—how else could they gain such traction within the imagination of lay people—but the expectations subsequently become unduly magnified. I am concerned with the problematic expectations that health-care professionals will certainly deliver upon the profound promise of health insinuated by technological advancement and its successful applications. The achievements of Western medicine have fostered false hopes and expectations about what the medical complex is able reasonably to deliver. Those men and women who work within medicine have, in some ways, convinced themselves of the

[9] Walls, 6.

[10] Ibid.

facticity of the fiction: of the wishful thinking that medicine can always, in time, effect a cure. This is not to say, of course, that medicine engages in utter fantasy. It is to say, simply, that these often unreasonable hopes persuade patients and professionals alike to continue in the bright hope of future development, even at the expense of great emotional trauma to the suffering person.

Medicine's hopeful stance has formed and been constructed into a kind of identity framework that accounts for the ways professionals act toward their patients and toward one another. This narrative validates the ways that practitioners act in the world professionally, but in doing so, it offers unreasonable promises about medicine's capabilities to heal and cure. Infused in the delivery of modern medical care is a hope that is problematically exaggerated. The healing arts are undertaken in the hope and belief that the sick body can be restored to some previous level of health or that through the careful management of bodily decline suffering can be eliminated. The hope is personal: the practitioner works at the bedside in the hope of restoring health to the patient. The hope is also corporate: biomedical research presses ever forward to find better treatments, faster cures, and more direct therapies. Not necessarily bad, these various forms of hope become distorted and problematically exaggerated within the eschatological narrative. Though medicine may not be able to master death, it comes ever closer to uncovering and describing the mysteries of physiology by means of which death can be delayed. From the bench to the bedside, research is translated into active clinical care in the hope of better serving the health needs of patients and prolonging life as long as humanly possible.

Despite the strides of technological improvement, patients currently suffer.

Though suffering is an ambiguous phenomenon, its alleviation is invoked as one of the moral ends of medicine. To better get a handle on an experience that is amorphous and hard to describe, health-care practitioners conceptualize suffering as a problem of the body and psyche. Once suffering has been interpreted as a problem, it becomes subject to all of the tools that medical research has to offer. Like any problem, suffering becomes subject to all of the analytical and descriptive tools of medical research; it can be described, studied, and analyzed, in the hope of being controlled and eventually eliminated.

The hope renewed in a person stems from medicine's response to such threats and is manifest in the promise of newer, better ways of manipulating, controlling, and ultimately saving the broken physical body. Whether through direct articulation or through implication, medicine promises cures through research and comfort through management of the body. The problems of vulnerability, terror, and death are negated by the hope within medicine's promise of future improvement. In medicine's eschatological narrative, better, more sophisticated medicine is the "radical remedy" to the problem. Additionally, the *problem* of suffering becomes something to be eliminated. Though traditional medicine is not explicitly engaged in achieving immortality, ingrained in the eschatological narrative is the image of the end time when death would be simply another part of life to be managed.

But medicine is *not* a religion: it just acts like one. It has not developed a full theodicy—that is, an understanding of the purposes of evil in the world. This limited understanding diminishes the chaotic reality of patient suffering and can even make aspects of suffering unintelligible. With nothing to help make sense of the miserable

mysteries that are a natural part of life, humans must place their hopes within themselves. Physician healers, who act in ways similar to those of priests, become unfairly charged with *saving* humans from illness, aging, vulnerability, and death. Scientific medicine's eschatological narrative differs from religious eschatologies, as Crossan explains them, in an important way. Crossan argues that religious eschatologies operate out of the "transcendental mandate" that requires them to respond radically to their perceived problem.[11] Medicine has adopted codes that at least tangentially invoke supernatural gods, but medicine never explicitly identifies a supernatural savior. Rather, the eschatological narrative posits the practitioner, his capabilities at controlling the unruly body, and the wide project of medicine as the enterprise that will save the human body from its vulnerabilities. Within this story, medicine's soteriology frames *itself* as redeemer, a secularized savior wrought by human mastery of the natural world.

The eschatological narrative, positing biomedical research as the thing which could save humans from life's vagrancies, makes a bad faith claim that humans *could* be saved from contingency, vulnerability, or death. This kind of claim is similar to Ernest Becker's discussion of immortality projects in his influential book, *The Denial of Death*.[12] Becker's philosophy is based on the claim that the world is inherently terrifying and unable to be ultimately controlled. According to Becker, humans are basically motivated to manage the anxiety of knowing that they will someday die. Humans unconsciously conspire both personally and at the societal level to keep the terror of impending death at bay. These efforts are demonstrated within medicine's eschatological narrative—a narrative that claims that terror could be sanitized and minimized via medicine's

[11] Crossan, *The Birth of Christianity*, 282.

[12] Ernest Becker, *The Denial of Death* (New York, NY: Free Press Paperbacks, 1997).

descriptive and analytical skills. Humans continue to die, of course, but the eschatological narrative encourages them to avoid the difficult task of recognizing and dealing with their anxiety by offering them an alternative vision of the future in which death need not cause fear at all.

Medicine's eschatological narrative works within medicine in such a way as to obscure and obfuscate the interpretive means available to practitioners who want to respond well to their patients' suffering. The hope of medicine, encapsulated by the narrative, is manifested through its promises of ever more sophisticated ways of controlling the body via technological advancement. The experience of suffering has little place within this exciting narrative; thus, suffering is marginalized or silenced altogether within the story. Practitioners and patients are both restricted by the finalizing nature of the narrative.

Unfortunately, the eschatological narrative is unrecognized within much of the practice of medicine. Instead the story has become internalized by those who are sick and by those who hope to heal. The story functions as a hidden cultural force within American medicine, impeding well-meaning physicians from accessing and engaging with their patients' true sources of suffering. Put another way, the eschatological narrative has become part of what Charles Taylor calls the "social imaginary," the unstructured, inarticulate background that informs the way large groups of people imagine their common, shared existence.[13]

The eschatological narrative has come to seem to be common sense. The

[13] Charles Taylor, *Modern Social Imaginaries* (Durham, NC: Duke University Press, 2004) and Peter Gratton, John Panteleimon Manoussakis, and Richard Kearney, *Traversing the Imaginary: Richard Kearney and the Postmodern Challenge* (Chicago, IL: Northwestern University Press, 2007).

anthropologist Clifford Geertz teaches, though, that "common sense" can be deceptive and dangerous:

> As frame for thought, and a species of it, common sense is as totalizing as any other: no religion is more dogmatic, no science more ambitious, no philosophy more general. Its tonalities are different, and so are the arguments to which it appeals, but like them—and like art and like ideology—it pretends to reach past illusion to truth, to, as we say, things as they are.[14]

As inherently social creatures, humans are always defining themselves in relation to the stories that they encounter; in the same way, humans act *upon* those stories. The humanities scholar Richard Waswo says as much in his article "The History That Literature Makes": "As the languages we speak determine how we know the world, so the stories those languages tell determine how we act in it."[15]

The internalization of the eschatological narrative as it becomes part of the social imaginary has consequences for practitioners. The psychiatrist Glen Havens reflects upon these consequences when he writes:

> Presuppositions or fundamental ways in which we perceive and structure our realities may not be well thought through. They may be emotionally based, unacknowledged, or even, to a large extent, unrealized. Nevertheless, they exist, for us, for our patients, and for their significant others. Furthermore, the biases that occur as a result of these presuppositions play a definite role in our decision-making process.[16]

Studying the development of an eschatological narrative within medicine and reflecting upon its implications for patient care can uncover some of these biases and

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[14] Clifford Geertz, *Local Knowledge: Further Essays in Interpretive Anthropology* (New York, NY: Basic Books, 1983), 84.

[15] Waswo, 541.

[16] Glen Havens, "Psychosocial Implications of Providing Nutrition and Hydration to Patients," *Issues in Law and Medicine* 2, no. 4 (January 1987): 301–315.

presuppositions that Havens considers—as well as some of the real dangers that such habits of thought portend.

To understand how the eschatological narrative could come to be and come to gain cultural authority, one must understand how a story so religiously infused could come to be a part of secular medicine. To explore similarities, one needs a working understanding of the nature of religion, how it functions, and what similarities it shares with medicine and religion. The adoption of an eschatological narrative is but one of several religious-type strategies that medicine has adopted to suit its ultimate goals of controlling the unruly human body. The under-recognized connectedness between religion and medicine continues to affect and even define relationships between patients and practitioners, as well as the expectations that each has for the other. Understanding the complexities of the eschatological narrative depends on the recognition, first, of the various ways that medicine and religion share functional similarities.

Speaking of religion is complicated, and speaking of faith can be downright risky, sparking concerns of evangelism, zealotry, and intolerance on the part of the speaker. For many scholars, talk of faith often arouses a fear that they may have a certain type of faith imposed upon them. Faith must always be a faith *in something*, and within religious circles, that faith is often (but not necessarily) a belief in a supernatural power who lies outside or beyond the scope of reason alone. The religious studies scholar Mark C. Taylor understands these difficulties when he acknowledges that "for many thoughtful people today, it no longer seems possible to think about God responsibly."[17] Fundamentalism, blind faith, and the invocation of God for the justification of atrocities

[17] Mark C. Taylor, *About Religion: Economies of Faith in Virtual Culture* (Chicago, IL: University of Chicago Press, 1999), 3.

has soured discussions of religion and faith for many reflective people. Indeed, many scholars adhere to the opinion that the secularist point of view is more nuanced, educated, and generally evolved than any point of view that entertains ideas about religion. In this view, those who are religious are unenlightened folk who need to be pacified with fairy tales of the supernatural.

America's history of religious expression, or lack thereof, has been complicated since the colonies. Never within its history was America homogenously religious; likewise, America has never moved beyond religion to a wholly secular society.[18] Rather, American culture has always held religion and secularism in tension. The historians Jon Butler, Grant Wacker, and Randall Balmer have discussed the variety of ideologies and theologies among early Americans. Participation and individual belief ran the spectrum from great fervor to "doubt about religion altogether."[19]

America was always religious, and it was always secular. Early America's religious complexity foretells the complexity of religious life in America today. Religious traditions have always stood alongside those who would reject notions of the sacred. One can certainly identify as a secularist, though, and still study the ways in which faith and religion move within the world. Despite the deep secular strain that has always had a strong position within American culture, religions—particularly the Jewish and Christian traditions—have influenced American life. Furthermore, religions continue to shape culture in unacknowledged ways. The religious studies scholar James C.

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[18] For a slightly tongue in cheek, but still provocative editorial on the tyranny of the secular, see David Brooks, "Kicking the Secularist Habit," *Atlantic*, March 2003, accessed January 23, 2014, http://www.theatlantic.com/magazine/archive/2003/03/kicking-the-secularist-habit/302680/.

[19] Jon Butler, Grant Wacker, and Randall Balmber, *Religion in American Life: A Short History* (Oxford, UK: Oxford University Press, 2008), 9.

Livingston points out that legacies from religious traditions "continue, largely unconsciously, to shape the values and institutions of a society that may no longer hold a common religion or maintain an established church. We may be fairly certain that the complex yet ordered fabric of any culture is woven from the loom of fundamental religious assumptions, loyalties, and hopes."[20] Taylor agrees, arguing for the necessity of studying religion even in areas that appear to be nonreligious. He writes, "the study of religion exposes religious dimensions of ostensibly 'secular' culture, which usually remain undetected."[21]

Because religion and medicine both work at the interstices of birth, the life course, and death, they share fundamental similarities in the questions of meaning that they ask. Medicine does not present itself as inherently religious, and its secular focus prevents it from being a full religion; nevertheless, secular American medicine possesses strong religious components. Ignoring these features because of the perceived supremacy of secularity results in an impoverished understanding of medicine's not altogether rational or secular assumptions and goals. In light of Livingston's metaphor, Americans do well to examine the loom of religion that has woven its features into the fabric of modern medicine in the United States.

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[20] James C. Livingston, *Anatomy of the Sacred: An Introduction to Religion* (Upper Saddle River, NJ: Prentice Hall, 2008), 12.

[21] Taylor, *About Religion*, 1.

RELIGION DEFINED

To understand how medicine functions in religious ways, one must understand what is meant by the term *religion.* Defining religion is no easy task. Within the study of the philosophy of religion, scholars have grappled with finding an overarching essential definition that can capture the richness and complexity of each religion. Part of the challenge lies in the ubiquity of religion; religious traditions are found within every group in the world, with humans of every culture seemingly inclined to give interpretations of a "greater reality, which lies beyond, or invisibly infuses the world that we can perceive with our five senses."[22] Livingston describes religion as a way of living on a threshold, mindful of something more.[23] This *something* is inspiring, fascinating, and mysterious. That one can consider a greater reality is uniquely human, and the capacity for self-awareness places humans in a privileged place among creatures. Constituted in bodies that must be fed and sheltered, humans also have the ability to reflect upon questions of ultimate meaning and significance. They have the unique ability among living beings to query the meaning of life and to establish systems that make the world seem coherent in light of life's difficulties.

Within the academic study of religion, scholars have attempted to define religion in terms of belief in a supernatural god or gods, an ethical system, human perceptions of the ineffable, and intuitions that lead to feelings of dependence upon the infinite. Some define religion in terms of humans in relation to cosmic powers (with the term *power*

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[22] Mary Pat Fisher, *Living Religions: An Encyclopedia of the World's Faiths* (London, UK: I. B. Tauris, 1997), 12.

[23] Livingston, *Anatomy of the Sacred*, 4-8.

remaining vague), while others give naturalistic definitions that posit religion as an entirely human creation. Some religious traditions affirm the existence of a god or gods, while others have an nontheistic structure.[24]

John Hick poetically points out that "the phenomenology of religion is a vast jungle of proliferating diversity in which discordant facts have continually attacked and destroyed large-scale theories and in which few generalisations have been able to survive."[25] The varieties of religious experiences have made defining religion by a single characteristic or essence impossible, but broad categories of definitions, namely functional and substantive categories, have emerged.

Functional definitions examine the psychological and social *uses* of religion. Defining religion by its usefulness gives a way of explaining why religions are omnipresent and have such cultural staying power. Substantive definitions of religion focus upon religion as something unique and peculiar in and of itself. Interested scholars have examined the world-making features of religion and the ways that religious believers manifest their experiences.

Each functional and substantive definition captures some part of the varieties of religious experience and the ways that religion manifests itself in human societies and cultures, but none can capture the diversity of religion entirely. The religious studies scholars Alston, Hick, and McKinnon agree that since no one definition can capture the one irreducible essence of religion, the more appropriate way to define religion is to

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[24] Compare, for instance, the multiple gods worshiped in Hindu traditions with Theravada Buddhism, which espouses no god as divine.

[25] John Hick, *An Interpretation of Religion: Human Responses to the Transcendent* (New Haven, CT: Yale University Press, 2005), 21.

understand it in more inclusive terms. They approach the definition of religion using philosopher Ludwig Wittgenstein's concept of "family resemblances." Wittgenstein's term refers to a group of items or concepts that cannot be reduced to an essence, but nevertheless share overlapping characteristics.[26]

Those scholars who draw from Wittgenstein suggest that instead of searching for one definable essence of religion, scholars pay attention to a series of religious features or characteristics that can combine in stronger or weaker ways. If enough characteristics are in place to a strong enough degree, then one can argue that the set of human behaviors or activities constitutes a religion. Scholars may argue over what constitutes "enough" characteristics or how much is "strong enough." The point, though, is that while none of the features by itself defines religion, one can, through the permutations of important characteristics, move towards more fitting answers to what one can call *religious*.

The family-resemblance view of religion is compelling for its scope and also for the features revealed. By looking at these features, medical humanists Harold Y. Vanderpool, Jeffrey S. Levin, and Daniel Goldberg have demonstrated how medicine exhibits religion-making characteristics; through these characteristics they show how medicine functions in religious ways.[27] Even though medicine's religious features may not be numerous or strong enough for medicine to rise to the status of a full religion, in the ways that its practitioners negotiate the experiences of health, illness, vulnerability,

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[26] Ludwig Wittgenstein, *Philosophical Investigations: The English Text of the Third Edition,* trans. G. E. M. Anscombe (New York, NY: Prentice Hall, 1958).

[27] Harold Y. Vanderpool and Jeffrey S. Levin, "Religion and Medicine: How Are They Related?," *Journal of Religion and Health* 29, no. 1 (Spring 1990): 9–20; Daniel Goldberg, "Religion, the Culture of Biomedicine, and the Tremendum: Towards a Non-Essentialist Analysis of Interconnection," *Journal of Religion and Health* 46, no. 1 (Spring 2007): 99–108; and Harold Y. Vanderpool, "The Religious Features of Scientific Medicine," *Kennedy Institute of Ethics Journal* 18, no. 3 (September 2008): 203–234.

frailty, and death, medicine too engages in interpretive work with that which lies beyond immediate sensory perception.[28]

MEDICINE'S OTHER RELIGIOUS FEATURES

The eschatological narrative could not have taken hold had there not already been a deep connection between medicine and religion. Medicine adopted and utilized religion-making features in its moral codes perceived to be sanctioned by gods, its use of symbols, notions of the sacred and profane, ritual acts that attend to or invoke the power held within perceived sacred objects and the numinous feelings that accompany associations with such objects.[29] Each of these characteristics participates in creating a milieu that could support the acceptance of a faith-based narrative such as the eschatological narrative. The eschatological narrative matured alongside medicine's other

[28] Carla Messikomer, Renée Fox, and Judith Swazey describe religion in this way: "The underlying conception of religion . . . is oriented to basic and transcendent aspects of the human condition, and enduring problems of meaning, to questions about human origins, identity, and destiny; the "whys" of pain and suffering, injustice and evil; the mysteries of life and death; and the wonders and enigmas of hope and endurance, compassion and caring, forgiveness and love." Carla Messikomer, Renée Fox, and Judith Swazey, "The Presence and Influence of Religion in American Bioethics," *Perspectives in Biology and Medicine* 44, no. 4 (Autumn 2001): 458–508, 486–87.

[29] Theravada Buddhism demonstrates that even one of the world's most prominent religions need not promote or entail worshiping a supernatural god or gods; likewise, the wide project of medicine does not require a physician or health-care practitioner to believe in or worship any particular god or gods. Yet moral codes of medicine still recited by practitioners are situated within a lineage that has directly acknowledged supernatural gods. Each oath recognizes a moral code that is particular to those who work to heal the ill, and the profession of the oaths serves as a rite of passage and a ritual moment that connects the new healers to a professional, ancestral past. The Hippocratic Oath, taken by medical school graduates, has changed over time and has largely removed invocations to deities, but the original oath invoked Apollo, Asclepius, Hygeia, Panaceia and "all the gods and goddesses." The nurses' Nightingale Pledge, written in 1893, calls its nurses to make the oath "before God." The Oath of Maimonides connects unabashedly the healer as supplicant to God as the provider of strength, support, and talent. See Ludwig Edelstein, Owsei Temkin, and C. Lilian Temkin, eds., *Ancient Medicine: Selected Papers of Ludwig Edelstein* (Baltimore, MD: Johns Hopkins University Press, 1987) and "The Florence Nightingale Pledge," accessed January 4, 2014, http://members.efn.org/~nurses/pledge.html.

religious features. Those other religious characteristics help solidify the foundation that supports the acceptance of a faith-based, though secular, eschatological narrative.

Medicine's use of structural symbols reinforces the notion that clinicians have salvific qualities and that the hospital and clinic are set apart as spaces full of promise. One can easily identify symbols that make one think of healing: the stethoscope, the ambulance, or scrubs, for example. Some familiar images are nearly obsolete in actual practice, like the head-light or the black medical bag used for house calls. Other symbols are auditory, such as the tolling of church bells or the Islamic *adhan*, the call to prayer, which invites believers to enter a holy space or engage in prayer, the wailing of ambulance sirens that tells drivers to get out of the way. The sound connotes an important way that medicine is authorized to suspend general rules and make an active societal intervention. The relationship between the symbol and that which it signifies is not direct and uncomplicated. Rather, symbols may suggest a whole host of meanings. They point beyond themselves, mediating, communicating, and connoting messages. They can call people into particular subjectivities—for example, the hospital gown authorizes a person's identity as patient. In the ways religion considers that "greater reality, which lies beyond, or invisibly infuses the world that we can perceive with our five senses," symbols act as a sort of shorthand to communicate multiple meanings. As physician and scholar Allen Peterkin observes, "Being a doctor means understanding that words and symbols always have more than one meaning—nothing is black or white, or even stagnant, in human experience and meaning-making."[30] Patients may identify

[30] Allan Peterkin, "White Coat Ceremonies--Not So White (or Black)?," *Atrium,* no. 9 (Spring 2011), 24–26.

medical symbols as having certain connotations, even if or when physicians project other meanings upon them.

Medicine utilizes symbols in similar ways to religion, but it also utilizes symbols that are more explicitly religious in nature. Vanderpool argues that "because they are not verbalized, medicine's religious symbols do not demand attention, but they nevertheless display and convey core religious values."[31] One clinical symbol that has garnered direct attention and inspired a scholarly literature within medicine is the white coat.

The white coat has become a site of analysis of medical symbolism more generally. Scholars have discussed how the white coat of the physician signifies much more than a professional garment. It connotes power, authority, and specialized knowledge.[32] The color of the coat was originally designed to emulate scientists, since through science, medicine gained empirical knowledge that gave the profession credibility. Vanderpool and Peterkin, drawing upon Dan W. Blumhagen's seminal article, discuss the more overtly religious symbolism of the white coat.[33] Vanderpool argues that whiteness "symbolizes mysterious and divine power" and cites the wearing of white as having divine importance within the books of Daniel, Revelation, and the gospel

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[31] Vanderpool, 217.

[32] The *Journal of Experimental Social Psychology* recently published findings, reviewed in the *New York Times*, which illustrate the power of representational symbols. The studies showed that people behave differently when wearing a white coat believed to be a physician's instead of a white coat believed to be an artist's. If the lay person had an understanding of a white coat's symbolic meaning for doctors, then that person wearing the coat demonstrated heightened and sustained attention and awareness. Sandra Blakeslee, "Clothes and Self-Perception," *New York Times*, sec. Science, April 3, 2012, accessed November 8, 2014, http://www.nytimes.com/2012/04/03/science/clothes-and-self-perception.html?_r=0.

[33] Dan W. Blumhagen, "The Doctor's White Coat: The Image of the Physician in Modern America," *Annals of Internal Medicine* 91, no. 1 (July 1, 1979): 111–116.

of Matthew.[34] Peterkin concurs, writing that "white . . . invoked religious references to Moses, Jesus, and the saints, all of whom were described as being cloaked in white in their roles as spiritual leaders."[35] Goldberg calls the white coat "the object that marks the medical practitioner as acolyte to the sacred realm [of medicine]."[36] Peterkin recalls his own experience as a medical student and describes how the symbolism of the white coat afforded him elite access into extremely private spaces. Though Peterkin was nothing more than a student, his white coat was like a vestment:

> When I was a medical student my beeper felt like a teleporter. One moment I would be eating lumpy macaroni and cheese in the cafeteria, then the ring of my beeper would transport me into another person's universe, their deeply personal reality. The beeper summoned me, but the white coat is what allowed me entry. The patients in those beds would tell me (a perfect stranger in a familiar uniform) things they might not have told to anyone else. People of different ages, races, languages, social statures or physical realities allowed me to touch their bodies; they allowed me to take part in their life and death decisions.[37]

Garbed in the white coat, physicians begin rituals necessary to achieve the restoration of health. The ritual of the medical encounter helps the patient to understand his role and responsibilities as a sick person.[38] Entering into the clinic with a complaint, the patient knows that he will be required to answer a series of questions. The physician asks the patient why he came to the clinic or hospital, both areas set apart for private

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[34] Vanderpool, 218.

[35] The white coat, though a powerful symbol of cleanliness, purity, and hope, is not medicine's only feature to have symbolic properties that directly borrow symbols used by religion. The serpent, who lured Eve to forbidden knowledge and who was used to heal people in the Hebrew Bible's book of Exodus, also appears surrounding the rod of Asclepius, a common emblem and symbol of medicine.

[36] Goldberg, "Religion, the Culture of Biomedicine, and the Tremendum," 102.

[37] Peterkin, "White Coat Ceremonies--Not So White (or Black)?," 25–26.

[38] For more analysis of the sick role, see Talcott Parsons' seminal book, *The Social System* (London: UK, Routledge, 1991).

conversations. In these spaces, the normal rules of social propriety are modified. The patient can disrobe without fear of molestation. He can also speak freely about intimate and personal details in confidence and with the confidence that his trust will not be violated by the physician.

The act of presenting symptoms to a health-care practitioner is not wholly different from confession in the Roman Catholic tradition. The roles of sin and sickness (sin as spiritual sickness or physical symptoms as manifestations of spiritual sin) have often been blurred throughout the history of medicine; I am not offering any argument to suggest that sickness is related to sin. Such matters of faith are beyond the scope of this project. The way that the clinical encounter functions, however, shares similarities to the act of confession. In confessionals, a person engages a cleric in a space set aside for private conversation. After confessing transgressions to a cleric, who by virtue of his ordination has been authorized to grant absolution of sins, the penitent is given a series of prayers or actions to complete as penance. In the clinical encounter, the patient enters with a problem and tells the physician about his or her private actions in the hopes that the symptoms can be mitigated. Through the careful consideration of symptoms and behaviors, the physician can prescribe some sort of “penance" in the form of antibiotics, behavior modifications, or surgery, that can lead to the “absolution” of the symptoms or "failures" of bodily function. Across the life span, these cures work, saving the body from the sicknesses that could lead to death. The rituals of medicine help create coherence and order within the hospital and clinic and facilitate the kind of healing that reinforces the expectations of the eschatological narrative.

These rituals also help practitioners engage with the numinous aspects of their practices. The sacred and profane, whose relationship according to religious scholar Mircea Eliade is the central dimension of religion, figures powerfully into the practice of medicine.[39] The sacred establishes itself in dynamic tension with the profane. The sacred is set apart from the profane as something venerable, worthy of respect, and inspiring terror or awe. Within medicine, the restoration of wholeness of the human body is held as an ideal. Combined with the mysteries of human physiology, the ambiguity inherent in clinical decision making, and the reality of medicine's limits, the relationship of the physician to the body can be considered, in Eliade's understanding of religion, to be sacred.

The surgeon Richard Selzer captures well the fascinating terror of seeing what lies underneath the skin during surgery:

> To how many men is it given to look upon their own spleens, their hearts, and live? . . . I pause in the midst of an operation being performed under spinal anesthesia to observe the face of my patient. . . . He is not asleep but rather stares straight upward, his attention riveted, a look of terrible discovery, of wonder upon his face. Watch him. This man is violating a taboo. I follow his gaze upward, and see in the great operating lamp suspended above his belly the reflection of his viscera. There is the liver, dark and turgid above, there the loops of his bowel winding slow, there his blood runs extravagantly. It is that which he sees and studies with so much horror and fascination. I feel it, too, and quickly bend above his open body to shield it from his view. . . . And I am no longer a surgeon, but a hierophant who must do magic to ward off the punishment of the angry gods.[40]

The ability to see inside the human body powerfully reflects the way that the sacred and profane are in relationship with one another. Historically, serious study of

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[39] Mircea Eliade, *The Sacred and the Profane: The Nature of Religion* (San Diego, CA: Harcourt Brace Jovanovich, 1987).

[40] Richard Selzer, *Mortal Lessons: Notes on the Art of Surgery* (Orlando, FL: Harcourt, 1996), 24-25.

dissection and human anatomy was accomplished using means considered to be profane, such as grave robbing, for the noble, even sacred, ends of achieving knowledge. Even now, physicians and students recognize the pregnancy of meaning in the anatomical encounter. Cutting into a human cadaver can summon the feelings of fascination, terror, dread, and awe. In such a moment, students can respond in different ways. They may cultivate a measured reverence in relation to these feelings. They may take solace in dark gallows humor. Others may dismiss, ignore, or suppress these complicated emotions. With time, the sacred components of the encounter with the body can become mechanical and routine; in these times, the profane dominates. Katharine Treadway, a Boston physician and Harvard Medical School faculty member concerned with the sensitization by practitioners to suffering and death, describes the intrusion of banality into the encounter with the once living human body:

> Where did we learn this detachment? For most of us, the first lessons came very early in medical school, when we were confronted with the dissection of a human body—conveniently called a cadaver, as though that made it something different from a person who had died. How rapidly we moved from our first tentative slices through the chest wall to look at the heart and lungs and then into the abdomen, finding ourselves lost in the fascination of how our bodies are arranged and overwhelmed by all we had to learn. Soon, we were casually slicing the head in half with a saw to see how it looked from the middle, having paused only briefly when we first unwrapped the hand, which struck us as uniquely and somehow poignantly human.[41]

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[41] Katharine Treadway, "The Code," *New England Journal of Medicine* 357, no. 13 (September 27, 2007): 1274. Many medical schools, including the University of Texas Medical Branch at Galveston, now hold ceremonies honoring those people who have donated their bodies to medical science. A recent article in the *Chicago Tribune* highlighted the ceremony performed at the Stritch School of Medicine at Loyola University. In the article, the director of the anatomy course reflected upon how the study of human anatomy includes sacred and profane components. "It's a balance between the sacred and the profane," Dauzvardis [the course director] said. "Here they're doing the most profane thing possible—disassembling the human body. We also have to hit the students' reset button a little bit to remind them there's the sacred— a spirit, a life and a body. . . . We have to remind them of that. It's part of what the ceremony is for." Medicine's rituals, like its symbols, are pregnant with meaning, directing participants to consider the mysteries of life, death, illness, and vulnerability. Manya Brachear, "Gross Anatomy at Catholic School Teaches Sacred, Profane," *Chicagotribune.com*, accessed December 8, 2014,

By virtue of their special role, physicians are privy to seeing human anatomy in ways few lay people are allowed.[42] Selzer gains access to the body's interior landscape because his hands can improve the life of the patient. The patient expects that, though recovery may be contingent, incomplete, or difficult, life will be maintained. The eschatological narrative authorizes Selzer to *save* the patient from disease. He accesses the kind of hidden knowledge that is denied the lay person. Though Selzer is not a priest, he likens himself to a hierophant, the ancient figure who interprets sacred mysteries. Selzer accesses something beyond immediate sensory perception in the way that he engages in his surgical techniques, and that *something* is awe-inducing and terrifying. He accesses these numinous feelings in the service of taking care of his patient and restoring a level of health to his patient. The patient, in turn, trusts the physician to violate the taboos so that he can be saved from the malady that brought him to the table.

Though discussed by other physicians, the eschatological narrative was most powerfully and explicitly articulated by the esteemed, brilliant physician Sir William Osler. Speaking to an audience of 2,500 in the McEwan Hall at the University of Edinburgh on a Sunday in the summer of 1910, Osler delivered what he called a "lay sermon" titled *Man's Redemption of Man*.[43] With soaring and intoxicating language,

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http://articles.chicagotribune.com/2011-08-30/news/ct-met-loyola-anatomy-blessing-20110830_1_anatomical-gift-association-gross-anatomy-cadavers.

[42] Gunther Von Hagens' *Body Worlds* exhibit, which displays human bodies that have been preserved through plasticization, has set as one of its goals the democratization of seeing under the flesh, as well as undermining the taboos connected to the privacy about the body. The *Body Worlds* exhibit has sparked vigorous debate about human dignity, the grotesque, and the role of entertainment in education. See Lawrence Burns's article and the subsequent commentary: Lawrence Burns, "Gunther von Hagens' BODY WORLDS: Selling Beautiful Education," *American Journal of Bioethics* 7, no. 4 (April 2007): 12–23.

[43] William Osler, *Man's Redemption of Man: A Lay Sermon*, accessed December 8, 2014, http://www.gutenberg.org/ebooks/36926. All subsequent quotations in the next several paragraphs of my text come from the online edition of Osler's sermon.

Osler spoke with the intent to move both the heart and minds of his listeners. Osler, who was widely read, integrated his knowledge of Christianity, his understanding of Greco-Roman history, and the optimism of the early twentieth century to create a narrative that culminates with the hope, promise, and expectation of medicine's salvific potential. He clearly used religious language, but in his great story, the sacred human was the one before whom patients should place their petitions, for it is man who will redeem them from the miseries of life.

Within the first minutes of the sermon, Osler presented the problem of evil: "and so red in tooth and claw with ravin is Nature, that, it is said, no animal in a wild state dies a natural death. The history of man is the story of a great martyrdom—plague, pestilence and famine, battle and murder, crimes unspeakable, tortures inconceivable, and the inhumanity of man to man has even outdone what appear to be atrocities in nature." Beyond these horrors lie more questions of chaos and meaning causing Osler to lament both the "great gulf" that seems to divide wretched humans with their sustained misfortune from the good God of Creation and the weak comfort provided in the promise of a better future in the afterlife.

Instead of focusing on the promises set forth in specifically Judeo-Christian religious texts, Osler turns his eyes toward ancient Greece, calling it the "tap-root of modern science." In the Hellenic world, Osler finds a proactive people who strive "to make life a better thing than it is, and to help in the service of man." Eventually the Greco-Roman world fell away, but Osler happily moves his audience toward the "revival of learning [that] awakened … a conviction that salvation lay in a return to the old Greek

fathers." The recovery of Greek ideals, for Osler, leads to the study of chemistry, the development of experimentation, and the dawning of the modern sciences.

Osler goes on to argue that the development of the sciences revolutionizes how humans interact with the natural world in at least three critical ways. First, Darwin's research "has so turned man right-about-face that, no longer looking back with regret upon a Paradise Lost, he feels already within the gates of a Paradise Regained." Second, modern science granted man dominion over nature by giving him the possibility of controlling earth, fire, air, and water. In support of this claim, Osler quotes a Rudyard Kipling poem that invokes Judeo-Christian images of creation, Adam, and the Garden of Eden. Third, "the leaves of the tree of science have availed for the healing of the nations," he says. Human sovereignty over nature is to be used in service of restoring health.

For Osler, none of the developments of the world could possibly compare to the "decrease of disease and suffering" in humans. Upon the "altars of science" men have worked for "man's physical redemption," and in doing so, have actualized the greatest of all promises. Through the developments of modern medicine, scientists and physicians have fulfilled the Promethean prophecy that "neither shall there be any more pain."[44] Osler proclaims that through experimentation, "the curse of Eve was removed" and "the knife has been robbed of its terrors." The realization of the promise of the eradication of pain inspires Osler to declare that humans have reached the Elysian fields in which acute infections can be prevented through sanitation, vaccination, and scientific preventative medicine. In only a generation, Osler says, man managed to control cholera, rein in

[44] Prometheus is known in Greek mythology as a savior figure, bringing light and fire to human kind. Angering Zeus, father of the Gods, Prometheus was punished for his efforts and chained to a rock on a mountain and forced to have his liver eaten by a bird each day.

malaria, and discover the cause of tuberculosis. The future shines brightly for Osler as he proudly declares that "the outlook for the world as represented by Mary and John, and Jennie and Tom has never been so hopeful. There is no place for despondency and despair . . . in this new gospel."

With this ebullient proclamation, Osler presents his listeners with the methods for responding to sickness and pain. Osler's words push suffering not just to the edges and margins of care. For the brilliant, compassionate, and optimistic Osler, there is simply *no place* in medicine where suffering is authorized. He goes on to invoke Shelley and the final image, in *Prometheus Unbound*, of almighty salvation brought through the work of human hands: "Happiness And [sic] Science dawn though late upon the earth; Peace cheers the mind, health renovates the frame; Disease and pleasure cease to mingle here, Reason and passion cease to combat there, whilst mind unfettered o'er the earth extends Its all subduing energies, and wields The sceptre of a vast dominion there."

A century later, Osler's exclamations of the fulfillment of the Promethean prophesy, with humans being their own saviors, have not come to pass; Elysium still lies on the horizon. Despite Osler's proclamations, even the most premier cancer therapy cannot protect the person in remission from the ever-present threat of his or her cancer's resurgence. The knife still wounds; pains still grip the helpless; and while the most elite medical technology may be able to postpone death for a season, the life cycle always has a permanent end. Humans still live in a world marked by disease, vulnerability, and mortality, and within the hallowed halls of the hospital and clinic, reason and passion have not achieved Osler's claim of integration. Yet even with these nonnegotiable

realities, the hope for a better tomorrow and the possibilities for what medicine can do for the fickle body continue to have tremendous power.

A 2010 empirical, qualitative study published in the journal *Cancer* demonstrates how faith and hope are performed in one group of sick patients. Daniel P. Sulmasy and colleagues examine the phenomenon of the therapeutic misconception, a name that medical ethicists have given to describe a research participant's belief that an experimental trial will yield a therapeutic benefit for the specific individual even though statistical probabilities may reflect only a small or unknown chance of benefit.[45] The authors of the study interviewed forty-five persons with cancer who had elected to enroll in early phase oncology trials. The goal of the study was to determine whether the participants operated under the therapeutic misconception and to understand more deeply the participants' individual reasons for enrolling in the early phase trials. The authors discovered that only one subject reflected a true therapeutic misconception. When talking about the statistical percentages of recovery or benefit, the subjects understood cognitively that they were guaranteed no benefit. The belief in expected benefit was connected *not* to a misunderstanding of the numbers, but rather to complicated expressions of hope, optimism, and faith. Subjects used these terms interchangeably, and often they reflected conflated hope, belief, or faith in God, medicine, and science. None recognized an eschatological motive to their beliefs, but the descriptions of their motivations reveal the multiple ways that faith is performed in the medical space.

Nearly all of the participants understood themselves to be engaged in a fight with their disease. Some interpreted their optimism as a tangible sign of the battle, proving

[45] Daniel P. Sulmasy, Alan B. Astrow, M. Kai He, Damon M. Seils, Ellyn Micco, and Kevin P. Weinfurt, "The Culture of Faith and Hope," *Cancer* 116, no. 15 (August 1, 2010): 3702–3711.

that they had not relinquished hope. Some suggested that a hopeful attitude would actually correlate with a better outcome; others believed that scientific research corroborated this belief. Others described their optimism as an attitude expected of them. In order to be a model patient or family member, they felt they needed to conform to expectations of optimism placed upon them by society, family members and loved ones, and their own health-care practitioners. Indeed, the eschatological narrative encourages an optimistic attitude, promising that if treatment is unsuccessful now, a time remains in the future when medical science will have developed a more efficacious therapy. The eschatological narrative provides a reason that some subjects also reflected an optimism that their involvement in the trials could lead to a future benefit to society. The expressions of altruism articulated by these subjects can be affirmed while still recognizing how the eschatological narrative places an expectation that each person participate in the collective progress towards a suffering-free future.

CONSEQUENCES OF MEDICINE'S ESCHATOLOGICAL NARRATIVE AND A PREVIEW OF SUBSEQUENT CHAPTERS

The legacies of the eschatological vision of medicine are far-reaching and entrenched; they have led to admittedly astonishing successes. The eschatological narrative's push toward the telos of corporeal mastery has yielded benefits that are tangible in each vaccine, antibiotic, and heart bypass. Patients who can afford care can usually expect real results that improve or restore healthiness; physicians can provide real options for keeping the body functioning well.

The eschatological narrative of medicine has other, unintended consequences, though. Those aspects of the human experience that do not fit into the eschatological plan of progress and redemption are marginalized, silenced, or made unintelligible within the medical encounter. Suffering, as I shall demonstrate in the next chapter, is characterized by its isolating, silencing nature. Indeed, suffering emerges to fill the silences alongside the distorted hope found in the eschatological narrative. Suffering, whose presence seems to undermine the possibility for physical redemption, is fed by the eschatological narrative even as the narrative attempts to save patients from that experience. The relationship between religion and medicine breaks down because modern, scientific medicine has no vocabulary within it to manage the chaotic elements that are enveloped within the concept of suffering.

My subsequent chapters will address the development and implications of the eschatological narrative and its inability to help practitioners respond to their patients' suffering. In chapter 2, I analyze the characteristics of suffering. While I reveal the general features of the eschatological narrative, I specifically examine its effects upon older patients. By exploring the experience of suffering among the elderly, I examine the ways suffering exposes the limits of the eschatological narrative. Elders, whose bodies' natural decline most starkly challenges the promises of the narrative, are also those whose suffering is often the most neglected. Thus, the suffering of the elderly patient helps simultaneously teach about the challenge of suffering and the limits of the eschatological narrative.

In chapter 3, I examine how the eschatological narrative could gain traction within the milieu of the late nineteenth and early twentieth centuries. I demonstrate how

the development of increased capacities for describing, managing, and controlling the physical body expanded into the promise of controlling the aging body. Explicit promises of mastering death became part of the medical promise to the aging person; an overlapping iteration of the narrative suggests that if death itself could not be mastered, then at least the aging process could be so controlled that suffering would have no impact. In chapter 4, I continue studying how the eschatological narrative has come to become part of medicine's social imaginary. I examine how the specialties of g1eriatrics and gerontology matured at the same time that the eschatological narrative came to be invisible. Furthermore, I demonstrate how the eschatological narrative continues to function as a story within the wide American discourse.

Between chapters 4 and 5, I return to the problem of suffering and argue that the medical humanities are well-suited to address the unique challenge of suffering within medicine. I tell the story of Francis Petrarch, who used reading and writing to make sense of his own sources of suffering. The *studia humanitatis*, which was a Renaissance curriculum for education the mind and heart, provides a basis for a way that modern gerontologists and geriatricians can move beyond the finalizing nature of the eschatological narrative in order to authentically respond and make meaning of their patients' suffering.

In chapter 5, I discuss the use of narrative and literary gerontology as a means for moving beyond the finalizing aspects of the eschatological narrative. I argue that the eschatological narrative can be put alongside other stories that interpret suffering and the human experience differently. I also argue that the development of narrative skills is necessary in order to engage most deeply with suffering patients. The intellectual

traditions and practices of the medical humanities offer invaluable methods for enabling health-care practitioners to understand, reevaluate, and revise the eschatological narrative. I discuss scholars within humanistic gerontology who are creating alternative interpretive spaces for practitioners and elders. Additionally, I discuss how the cultivation of the readerly and writerly self can help practitioners become more generous toward the parts of the human experience that are fundamentally mysterious. Finally, I discuss Wayne Booth's metaphor of literary friendship to discuss how texts can be used to help cultivate ways of thinking that can lead to more generous interpretations of suffering.

In chapter 6, I discuss certain stories that can become companions to medical practitioners, helping them cultivate a dialogical space that resists the eschatological narrative's false promises. I examine three different examples of texts that can be literary friends to practitioners: The book of Job from the Hebrew Bible, Buddhist wisdom texts, and the Shakespearean play *King Lear*. I argue that these texts engage with suffering in interesting ways and, combined with their historical longevity, make excellent teachers for practitioners who wish to move beyond the finalizing nature of the eschatological narrative. I conclude with a discussion of the future of the project.

CHAPTER 2: MAPPING THE TOPOGRAPHY OF SUFFERING

> I think, therefore I am is the statement of an intellectual who underrates toothaches. I feel, therefore I am is a truth much more universally valid, and it applies to everything that's alive. My self does not differ substantially from yours in terms of its thought. Many people, few ideas: we all think more or less the same, and we exchange, borrow, steal thoughts from one another. However, when someone steps on my foot, only I feel the pain. The basis of the self is not thought but suffering, which is the most fundamental of all feelings. While it suffers, not even a cat can doubt its unique and uninterchangeable self. In intense suffering the world disappears and each of us is alone with his self. Suffering is the university of egocentrism.
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> —Milan Kundera[46]

INTRODUCTION

From the broader examination of medicine's religious features and an introduction to the eschatological narrative, I will now explore effects that result from ignorance of the eschatological narrative's limits, particularly as they relate to the experience of human suffering. The eschatological narrative purports to assuage suffering through the application of medical knowledge, but that story falls short of deeply recognizing the multiple sources of suffering that can afflict a person. Without a conceptual understanding of suffering, practitioners who think with the story may believe that they are responding to a person's turmoil when they are, instead, hindered by the way that the narrative narrowly delineates what kind of response suffering should receive.

Though the eschatological narrative can affect persons with all varieties of life-threatening illnesses, aging and becoming old reveal the narrative's sharpest limits. The eschatological narrative's promises are revealed as problematic in light of the aging

[46] Milan Kundera, *Immortality* (New York, NY: HarperPerennial, 1999), 205.

body's visible and palpable limits, culminating in death. The aging person, in a body that serves as the site of the eschatological narrative's promises, starkly experiences the failures of the story as the effects of aging accumulate. The narrative offers a postured understanding of what it means to suffer, and the elderly person's suffering demonstrates the narrative's weaknesses. Because the eschatological narrative is noticeably connected with the suffering of elder persons, I shall use their suffering as a way of exploring the concept of suffering more generally.

The media's complicity in propagating medicine's eschatological narrative is not limited just to lauding the miracles of modern science. The promise of medical management, the expectation of cure, and the incoherence of suffering are performed in the social redefinition of age, aging, and becoming old. Indeed, the modern therapeutic culture makes demands of both physicians and patients that can increase the suffering of both parties. Hope and expectation of a "young" or "successful" old age inform gerontological research and its corresponding medical specialty, geriatric medicine; the enterprise of medical elder care, in turn, presents the promise of management of the old body grounded in its own eschatological hope for the future. The national news will serve as an opening wedge by which I will begin the process of confronting iterations of the eschatological narrative by unpacking the mutually constitutive myths that infuse old age, its relationship to modern American medicine, and the eschatological narratives' effects upon medicine's relationship with elderly patients.

In July 2011, *ABC World News with Diane Sawyer* ran a week's worth of segments on changing norms of retirement. The program crows that the generation known as the baby boomers, whom the Pew Research Center says are turning sixty-five

at a rate of ten thousand per day, are "rewriting the rules, living life on their own terms and turning ideas about retirement on its head."[47]

The segments, five in all, tell stories of men and women who are advanced in years but young in mind and body. The stories inspire: a retiree realizes his childhood dream of becoming a firefighter (the man had been a plastic surgeon); a professional is able to stop his full-time work but continues working part time as a consultant (the man has a PhD in atmospheric science); a seventy-five-year-old demonstrates her impressive physique (the woman is in the Guinness Book of World Records for body-building). The series was named "The Good Life," and each segment gave the impression that "the golden years" can, and should, be a time of vigor, vitality, and enormous fun.

One segment made an explicit connection between a retired couple and youth culture. The couple retired to Austin, Texas, for its low cost of living, intellectual opportunities, and thriving music and arts scene. "Guess who else wants that?" asks the reporter. "Their twenty-year-old grandchildren!" The reporter, Claire Shipman, goes on to observe, "It sounds like, almost, you're having a Renaissance of your youth." The gentleman in the couple smiles and responds, "Actually, in some cases, it's better. To me this is the best time."

Perhaps the viewer should expect that the tone of these stories would be encouraging and optimistic. The fervor of these segments is not tempered by the troubling story earlier in one of the broadcasts about retirees who are being denied pensions by a bankrupt city. In that story, one man angrily cried out that his only option is welfare. Never mind that, say segments like "The Good Life," which circumvents such

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[47] "The Good Life," *ABC World News with Diane Sawyer: Mon, Jul 18, 2011*, July 18, 2011, accessed May 10, 2014, http://www.hulu.com/watch/259437/abc-world-news-with-diane-sawyer-mon-jul-18-2011#x-0,vepisode,1,0.

troubles by presenting the health benefits of continuing to work late in life.

Each of the men and women presented in "The Good Life" segments appears to be educated, wealthy, and privileged. Their bodies cooperate and their minds are sharp. These people, as they are represented in the newscast, are untroubled. They do not suffer, and they send the not-so-subtle message that if the viewer lives like them, then he or she too will avoid suffering.

This series is a fine example of what the journalist and scholar Susan Jacoby calls the myth and marketing of the new old age.[48] This branding focuses squarely on what gerontologists call the "Third Age," that period of time after retirement but before illness and significant disability set in.[49] This time is one of radical freedom: Sandy Markwood, CEO of the National Association of Area Agencies on Aging, says: "At sixty-five and seventy, you really are freed up to do whatever it is that you want to do."[50] With the social obligation of family rearing finished, retirees can pursue interests that they might not have been able to during their early to middle adult years. "The Good Life" shows the exciting possibilities for those who are well-positioned enough to be able to cash in their privilege for their hard-won freedom for pursuits of pleasure.

Meanwhile, the technology company Google announced, in September 2013, that it was launching a "moon shot" biotech company called Calico, which focuses its

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[48] Susan Jacoby, *Never Say Die: The Myth and Marketing of the New Old Age* (New York, NY: Pantheon, 2011),

[49] See, for example, Robert S. Weiss and Scott A. Bass, eds., *Challenges of the Third Age: Meaning and Purpose in Later Life* (New York, NY: Oxford University Press, 2002).

[50] "The Good Life."

research upon aging and its corresponding diseases.[51] The ultimate aim of Calico is to conquer death by minimizing human disease and extending the life span. In describing the project, Jessica Guynn of the *Los Angeles Times* wrote, "For Google, nothing is off limits. Even death is on the firing line."[52]

Stories like these can be inspirational for some, and, without discounting that experience, one can admit that fortune has not looked so kindly on every older person. I am interested in how these stories and their connection with the medical care of the old have an impact upon the reality of elder suffering. Regardless of advantage and opportunity, with enough years of life, each will graduate from the young-old and become the old-old. Unsurprisingly, the ABC news segments never dare to call the retirees "old." The descriptor strikes fear, implying disability, frailty, lack of productivity, and general uselessness. Jacoby argues that *old* is interpreted more "as an expression of prejudice rather than a factual description of a stage of life."[53]

Aging and becoming old are intricately joined with life's inevitable boundary. Medicine's eschatological narrative offers hope that the boundary can be negotiated, pushed back, or, at its loftiest horizon, eliminated altogether. To "combat" the vicissitudes of age and the mystery of aging, contemporary gerontologists write, using

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[51] Leslie Miller, "Google Announces Calico, a New Company Focused on Health and Well-being," September 18, 2013, accessed December 8, 2014, http://googlepress.blogspot.com/2013/09/calico-announcement.html.

[52] Jessica Guynn, "Google Launches Healthcare Company Calico to Extend Life," *Los Angeles Times*, September 18, 2013, accessed December 8, 2014, http://articles.latimes.com/2013/sep/18/business/la-fi-google-aging-20130919.

[53] Jacoby, 5.

terms like *successful aging* and the *compression of morbidity*.[54] Social scientists have described ever more intricate and complicated risk patterns for aging while epidemiological studies describe the social factors that lead to health disparities among the elderly. The goals of such studies are important: improving understanding about social determinants of health leads to interventions that can improve the quality of life for the elderly and address social sources of suffering.

The aspirations of those who studied senescence and developed lines of scientific inquiry into the mechanisms of the aging process at the turn of the century were embedded within the same cultural forces that fostered the modern medical eschatology. The hope that inspired vast technological advancement is the same hope that fueled the efforts to demythologize and control aging processes. Elusive, veiled promises of management and cure of the aging body continue to drive the research agenda, and though those who study aging have made great inroads, geriatric medicine and gerontology have been unable to fully escape the medical model that holds its primary exemplar of success as health and lasting life, with death being the corresponding failure. Coupled with the driving hope of cure is modernity's lingering uneasiness with uncertainty, ambiguity, and particularity. The nature of suffering, whose sources are unique to each individual, resists the sort of generalizable, measurable response that fosters certainty.

The eschatological vision of aging has led to profound medical and social interventions for our elders that increase quality of life and help minimize debility. Unrecognized and unchecked, however, the vision prevents medical professionals from

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[54] See, for example, William Satariano, *Epidemiology of Aging: An Ecological Approach* (Sudbury, MA.: Jones and Bartlett Publishers, 2006): 13, 303.

recognizing, addressing, and interpreting elder suffering, especially suffering stemming from medicine's inability to deliver upon its veiled promise of immortality. Terms like *successful aging* and *healthy aging* imply that some could fail at aging—the same way that the eschatology of medicine places the expectation upon practitioners that they fail if they cannot deliver upon the promise of cure—or, in the case of practitioners of elder care, the hope of flourishing ablebodiedness until an uneventful death.

As discussed in chapter 1, the practice of medicine operates with tools similar to those of religion, from the uses of oaths, rituals, and symbols to devices that help make sense of the ubiquitous problems that are part of the human condition.[55] In the previous chapter, I made the claim that medicine and religion's functional similarities have made it possible for a particular story, which I have named the eschatological narrative, to become part of medicine's social imaginary of modern medicine.

In this chapter, I operationalize the term *suffering* by describing and explaining suffering's characteristics. Through a conceptual analysis of the term, I delve further into medicine's attempt to protect the physician and patient from suffering and explore how suffering exposes the limits of the eschatological narrative within medicine's cultural discourse. Situating the caregiver's response to suffering in a discourse dependent upon technological advancement and human mastery of the body limits the vocabularies upon which practitioners can draw to address the varieties of experience that could be characterized as human suffering.

In the midst of astonishing biomedical developments, stories of suffering too often go unacknowledged or unnoticed. The cycle of promise and fulfillment within the

[55] In this discussion of the religious features of modern medicine, I am not considering the ways that spirituality influences patient and practitioner interactions. Instead, I am studying how medicine and religions utilize similar organizational and functional strategies to create a coherent system of meaning.

eschatological narrative neglects to incorporate the deep recognition of the reality of suffering, which becomes marginalized from the medical discourse. Easing suffering is invoked as a lofty goal of care, but as one too nebulous and intangible for legitimate study. At its worst, the eschatological narrative suggests that the recognition of suffering be ignored as something beyond the scope of medical care. A conceptual understanding of suffering must be undertaken in order to understand how ill equipped the eschatological narrative is in helping individuals make sense of the experiences of the cumulative effects of age, illness, and eventual mortality.

Suffering is systematically isolating, disconnecting, and marginalizing. It leaves the person socially and spiritually impoverished, struggling to make meaning in a social environment that has fully rejected him at the worst and subtly but methodically devalued him at best. Medical professionals who focus only on the eschatological promises of medicine invoke the ideal of alleviating suffering, but, without examining the topology and potential sources of suffering, they can inadvertently compound and intensify their patients' suffering.

Eric J. Cassell's groundbreaking work in the *New England Journal of Medicine* (*NEJM*) and his subsequent book *The Nature of Suffering and the Goals of Medicine* remain perhaps the most prominent contribution to the understanding of medicine and suffering. Three decades have passed since his *NEJM* article, and suffering as a specific topic of study and teaching within medicine has remained largely separated from other disciplines.[56]

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[56] Eric J. Cassell, "The Nature of Suffering and the Goals of Medicine," *New England Journal of Medicine* 306, no.11 (March 18, 1982): 639–645; and *The Nature of Suffering and the Goals of Medicine* (New York, NY: Oxford University Press USA, 1994). The notable exception in medicine is found in

The compartmentalization of academic study has led to various literatures on suffering that have developed in relative isolation from one another. Understandably, the multiple ways of thinking about suffering make it all the more difficult for health-care workers to address suffering. Traditional medical theory has been problematic because it values and studies disease entities and processes at the expense of understanding the illness experience, and the ways that living with illness may shape the way suffering is perceived or embodied.[57] Coupled with the eschatological narrative of medicine, health-care professionals can rationalize the separating of themselves from the acknowledgment and management of suffering along with the other types of care that they deliver.

Understanding the particular ways that suffering can occur within the medical setting requires a broader understanding of suffering. In the spectra of human experience, what does it mean to *suffer*? Why can one's experience be called suffering rather than typical grief? Is suffering different from grief, or are the two synonymous? How does suffering relate to physical pain? What are other distinguishing properties of suffering? This dissertation is concerned with patient suffering, but suffering is not singular to the medical setting; indeed, suffering is a phenomenon shared by humans in settings across the world.

While the concept of suffering is broad, key characteristics do emerge. A more vivid portrait of suffering will emerge out of the description of the physical and emotional features of suffering, social sources of suffering, and spiritual or existential

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nursing literature. A body of qualitative literature studying the phenomenology of the illness experience has developed that has paid attention to the varieties of suffering.

[57] Examples of the medicalized body versus the experience of illness are identifiable within many first-person narratives of illness. See, for example, Arthur W. Frank, *At the Will of the Body: Reflections on Illness* (Boston, MA: Houghton Mifflin, 2002); and Fitzhugh Mullan, *Vital Signs: A Young Doctor's Struggle with Cancer* (New York: Farrar, Straus, Giroux, 1983).

features of suffering. Despite these categories, suffering resists neat distinctions. This messiness will be embraced even as the chapter moves forward and uncovers the complexities of suffering as well as illuminates reasons for the paradoxical nature of medicine's myopia toward suffering in the face of superior disease management.

The word *suffer* has etymological roots in Middle English (*suffren)*, Anglo-French (*suffrir*), and Latin.[58] The Latin prefix *sub-*, meaning "under" is paired with the Latin word *ferre*, meaning "to carry or bear." At its etymological core, *suffering* means "to bear under," and the directionality and heft contained within this etymology calls to mind an image of someone straining beneath an object of great mass. The theologian Dorothee Soelle, furthering the argument of Simone Weil, argues that suffering has three major components that contribute to this sense of suffering's tremendous weight. Profound psychological, physical, and social dimensions can transform otherwise negative experiences into true suffering.[59] I will examine each dimension in turn, then discuss the existential and religious dimensions of suffering.

PSYCHOLOGICAL DIMENSIONS OF SUFFERING

Grief is a recognized emotion within the space of medicine, but grief should not be conflated with suffering. Grief and suffering are not synonymous. A single event, such as a terrible diagnosis or the death of a loved one, may lead a person to suffer, but the suffering cannot be called immediate. Grief may precipitate profound emotions, and if those emotions continue over a length of time, they may lead a person to suffer. Grieving

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[58] *Merriam-Webster's Collegiate Dictionary*, 11th ed. (Springfield, MA: Merriam-Webster, 2003).

[59] Dorothee Soelle, *Suffering* (Philadelphia, PA: Fortress Press, 1984).

eases over time and eventually stops or becomes able to be tolerated. Suffering has a longer temporal component, with time offering no respite.

Suffering differs from grief in its length of duration, but it also generates deeper concerns about fundamental meaning. All sentient humans have the capacity to suffer, and suffering exists broadly along countless points of the spectrum of life. Why then, given the varieties of human wretchedness, do not humans suffer at all times? Suffering becomes a distinct phenomena in that the experience involves distinguishing characteristics. Suffering incorporates experiences of both powerlessness and meaninglessness through time. It entails more than grief, although unresolved grief may precipitate suffering. Cassell argues that suffering arises out of assaults to personhood; the potential for dissolution of the self creates the condition for suffering. Soelle's definition goes further. The assaulted person may be powerless to stop the experience and the lack of control intensifies suffering.

The illness experience is often marked by a lack of control and a betrayal by the body. Always with the person, yet always in relation to the person, always helping to define his or her sense of self, and yet never wholly defining him or her, the nature of embodiment has captivated the thoughts of philosophers and theologians for centuries. Although the effects of illness and aging are demonstrable in the faces and bodies of elders in society, when one's body is functioning properly, much of its workings can go unnoticed. Hands grasp and lungs breathe; kidneys filter, and legs ambulate. We can objectify our bodies, but as Auden writes in his poem "The Surgical Ward," ". . . who

when healthy could become a foot?"[60] Only the ill person could have his world reduced to one body part.

In an instant, illness disrupts the relationship that a person has with his body. Fredrik Svenaeus makes this point in his cogent analysis of the phenomenology of the illness experience. Drawing upon Freud and Heidegger, he discusses the *uncanniness* of illness and ways that the body becomes foreign, distant, and *unhomelike*.[61] That which was always most familiar to a person—one's very flesh—becomes something radically different. The feelings of "unhomelikeness" may not be a sensation that can even be expressed with language, but rather something that is apprehended in a deeply internal way.

Disabilities mount and the elder may become dependent on others for care. Men and women are living longer than their historical counterparts, but they are not necessarily living with better health.[62] Like the Greek character, Tythonos, who wished for immortality but forgot to wish for youthfulness, the elderly today continue to grow older without the physical benefits of a youthful body.

The experiences of decline and denigration can have profound emotional consequences and can lead an elder to suffer. For the elder, external marks on the body

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[60] W. H. Auden, "The Surgical Ward," in *Reading the Bible in the Strange World of Medicine.*, ed. Allen Verhey (Grand Rapids, MI: W. B. Eerdmans, 2003),108.

[61] Fredrik Svenaeus, "Das Unheimliche–Towards a Phenomenology of Illness," *Medicine, Health Care and Philosophy* 3, no. 1 (Summer 2000): 3–16.

[62] This last point is clearly true for native and foreign-born Hispanics who grow old in the United States, living longer than other ethnic groups, but with more disability. Karl Eschbach, Sonam Al-Snih, Kyriakos S. Markides, and James S. Goodwin, "Disability in Active Life Expectancy of Older U.S. and Foreign-born Mexican Americans;" and Mark D. Hayward, David F. Warner & Eileen M. Crimmin, "Does Longer Life Mean Better Health: Not for Native-born Mexican Americans in the HRS" in *The Health of Aging Hispanics the Mexican-origin Population* , ed. Jacqueline Lowe Angel and Keith E Whitfield (New York, NY: Springer, 2007), 85–98.

signify the natural, cumulative effects of time on the body. Sunspots, wrinkles, a slower, stooped gait, all definitively mark the person as old. The aged body, with its particular smells and sounds, can become stigmatizing, and while stigma may contribute nothing to the disease process, its psychological effects on perceptions and experience can be experienced as suffering. *Stigma*, coming from the Greek word meaning "to brand," negatively marks a person as someone detached from the typical. The mark is recognizable, shames the person, and signifies him or her as ugly, unclean, impure, or bad. *Badness* can range from plainly abnormal all the way to sheer evil.

When a younger person beholds the stigmatizing mark, whether it be a visual mark like atrophied muscles or another sign such as a cracked, warbling voice, she recoils. The younger person is viscerally reminded of her own body, its limits and limitations, and its ultimate contingency. In the stigmatic sign the younger person sees that she, too, is vulnerable. Fearing the complicated feelings that accompany the apprehension of the stigma, the younger person turns away, ignores it, and pretends that in avoiding the stigma, she will be protected from the contingencies that mark her own life. The stigmatized person—the self whose embodiment includes the stigma—is also ignored. The human that lies beyond the sign is isolated, shunned, and disconfirmed of her status as person.

The literary critic Katherine Woodward writes that old age is a time of both invisibility and *hyper*visibility. She invokes Freud's image of the mirror stage to call attention to the ways that the old body can stand in opposition to the self.[63] Woodward speaks of the story of Narcissus' pleasure in seeing his own image reflected back to him.

[63] Katherine Woodward, *Aging and Its Discontents: Freud and Other Fictions* (Bloomington, IN: Indiana University. Press, 1991).

Old age, though, can offer a much different reflection. Woodward writes, "We may think of ourselves as young, but others will perceive us as old, perhaps even ancient."[64] Following Simone de Beauvoir, Woodward argues that "old age belongs to the category of 'unrealizables.' *We* are not old; it is the Other, the stranger within us, who is old."[65] Society reflects back the elders' age in its response to the aged body.

The old body is unable to be hidden, although the market of beauty creams and plastic surgery would lead one to believe that it can be masked. Eventually, though, the effects of time cannot be erased from the body. When the elder's body is viewed as stigma, it becomes a perpetual reminder of otherness. The elder's experience of being shunned happens over and over again. The recoiling and subsequent turning away by others provides a constant and systematic mortar upon the pestle of the stigmatized self. The person, habitually isolated, internalizes the shame created by the stigma; that isolation feeds upon itself further, removing the person from the throngs of society. Isolation becomes another source of shame and a means for feeding the disconnected, hopeless feelings that are hallmarks of suffering. The elder has no psychological refuge when he or she suffers in the body that, while home, is also strange and horrible.

The experiences of illness and aging are not ready equipped with explanations of meaning and can leave the patient feeling bereft. A person can suffer from his unidentified symptoms because time passes and still he knows not why he feels the way

[64] Ibid., 62.

[65] Ibid.

that he does.[66] Why does the body suddenly feel foreign? What causes these unusual sensations? The physician and philosopher Drew Leder reminds readers that "the life-world is saturated with medical meanings," but the lay person is not always equipped to interpret them.[67] Having lived in a body and *been* that body for a lifetime, the elder knows the rhythms of his body better than anyone else. If the body radically changes, then the corresponding disruption to the psyche may be equally significant.

When a person is diagnosed with a disease, he may gain some relief knowing that his illness has a name, but that respite is often short-lived when treatment starts. Habits of life must change as the ill person's day becomes centered around clinic visits, physical therapy, and medication management. Oldness, for some elders, can feel like a chronic illness. For the real chronic diseases like diabetes and sarcopenia that often accompany aging, therapeutic treatments could last the remainder of a lifetime. A person's sense of self must be reshaped to include his illness. Not only is a person a mother, steelworker, dancer, or gourmand; for example, the person is also living with sclerotic arteries, mild dementia, or arthritis. Car keys (and the corresponding independence that accompanies driving) may be surrendered. Elders may have to renegotiate family power dynamics when they move into their adult children's homes. Cassell rightly argues that the "struggle between parts of the self can make the illness more severe and be a source of suffering."[68] These struggles easily give rise to a sense of disconnection from the broader world and a loss of rootedness in one's former life, with its own particularities. With no

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[66] See, for example, Nancy Mairs, *Waist-High in the World: A Life among the Nondisabled* (Boston, MA: Beacon Press, 1997); and Paul Monette, *Borrowed Time: An AIDS Memoir* (Orlando, FL: Mariner Books, 1998).

[67] Drew Leder, "Clinical Interpretation: The Hermeneutics of Medicine," *Theoretical Medicine and Bioethics* 11, no. 1 (March 1990): 17.

[68] Cassell, *The Nature of Suffering and the Goals of Medicine,* 59.

terminus to the treatment or vision of completion and return to youth, the misery of chronic illness and increasing dependence can feel interminable.

If health cannot be achieved, then why do treatments continue? Sometimes the answer lies in managing symptoms or improving quality of life. At other times, the drive comes from the explicit eschatological hope for moving ever closer toward the goal of conquering death and suffering, or its permutation, the eschatological promise of continued health up until the final ease into a silent, painless, unencumbered death.

Aging is not always marked by radical illness, though, and when it is not, simply becoming older can still be a potentially confusing experience. A person oftentimes maintains a sense of consistency of the self, preserving similar likes, dislikes, and values throughout a life. Gerontologist Harry R. Moody explains that "psychological aging [without radical illness] . . . is a far more subtle form of self-perception that follows its own mysterious rhythms and tides and pays little attention to bodily change or even to the linear passage of time."[69] As years accumulate within a person's life, he or she must revisit the sense of self and identity that may or may not be evolving.

Practitioners, too, can experience psychological dimensions of suffering including feelings of hopelessness and meaninglessness within the medical setting. If the practitioner is undervalued or underappreciated by his fellow employees, burnout can easily occur. Add to that a shrinking hospital budget that leads to understaffing, longer hours, and less time for nurturing the spirits of the providers. The swirling sea of exterior demands on the health-care worker (physician, nurse, and allied health professional alike) can translate to a lack of empathy and a draining of the good motives that attracted a

[69] Harry R. Moody and David Carroll, *The Five Stages of the Soul* (New York, NY: Anchor Books, 1997), 12.

person to medicine in the first place. The medical humanists Ellen Singer More and Maureen A. Milligan describe it well when they say, "empathic practice requires the negotiation of a practical balance between connection with another and the maintenance of one's sense of self."[70] Without this negotiation, physicians can become increasingly impaired, leading to feelings of isolation and/or problems with depression and addiction.[71] As the limits of the eschatological narrative are negotiated, the reality of death confronts the hopeful expectation of promise and cure. This day-in, day-out grind of taking care of sick people can disenchant the health-care worker, leading him to feel the same sense of powerlessness and lack of terminus that the sick person feels.

PHYSICAL DIMENSIONS OF SUFFERING

Sir William Osler made a special point of addressing pain in *Man's Redemption of Man*.[72] To be sure, the development of anesthesia brought significant relief from surgical incisions and amputations. Because pain and suffering are often so closely linked, the proclamation of victory over the pain of the knife is critical to the eschatological narrative. In legal documents, pain and suffering refer to any emotional or physical stress that results from an injury. In the medical literature, suffering and pain are often also spoken of simultaneously. The assumption that the two terms can be connected rests in medicine's eschatological vision: if pain is managed, then the suffering will also be

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[70] Ellen Singer More and Maureen A. Milligan, "The Empathic Practitioner: Empathy, Gender, and Medicine," Introduction to *The Empathic Practitioner: Empathy, Gender, and Medicine*, ed. Ellen Singer More and Maureen A. Milligan (New Brunswick, NJ: Rutgers University Press, 1994), 4.

[71] For example, see Marie R. Baldisseri, "Impaired Healthcare Professional," *Critical Care Medicine* 35 (February 2007): S106–S116; and Martin R. Petersen and Carol A. Burnett, "The Suicide Mortality of Working Physicians and Dentists," *Occupational Medicine* 58, no. 1 (January 1, 2008): 25–29.

[72] Osler, *Man's Redemption of Man*.

managed. By identifying pain with suffering, medical practitioners have, as it were, a somewhat more tangible object for which to search. If the health-care team can find the reason for the pain, so this way of thinking goes, then it can manage the pain and ameliorate the suffering.

Pain, however, is not so tangible as it might seem; furthermore, physical pain alone does not necessarily equate to suffering. Suffering's connection with pain is inherently bound with the meaning of pain, but pain and suffering are not necessarily the same thing. Unresolved pain can induce suffering, but pain should not be considered equivalent to suffering.

The experience of pain can be both a source of suffering or a tonic for it. Pain can induce suffering especially when the source of the pain is elusive. Without an understanding of the grounding force or reason for pain, it can become meaningless suffering. If one cannot understand *why* one feels a certain way, or for what purpose these feelings arise, despair fills in for the lack of meaning. The tennis player who aches knows that her pain is from her excellent match and has the understanding that her sore legs signify physical fitness. The student who endures grueling late-night study sessions and long nights of writing knows that her physical fatigue is part of the greater path toward her final academic goal. Both the tennis player and the student undertake their responsibilities willingly, because they know both the causes and the impermanence of their struggles. The improved skill and physique give meaning to the tennis player's pain; the satisfaction of mastering complex concepts gives meaning to the student's fatigue. In these examples neither pain nor exhaustion induces suffering because each experience is infused with meaning.

Correspondingly, disability in and of itself is not enough to make a person suffer, although it could contribute to the experience of suffering. As many disability scholars have argued, the presence of disability should not be assumed to equate with a poor quality of life.[73] Suffering can be avoided when the source of or reason for physical pain is recognized and accommodated. The eschatological hope of curing the disability may not be fulfilled, but the easing of pain can temper suffering.[74]

Meaninglessness can result from the inability of medicine to find a direct correlation between symptoms and disease expressions. Francis W. Peabody attended to this problem of the legitimization of symptoms in his 1927 address, "The Care of the Patient." What happens when the source of pain cannot be determined? Peabody describes a patient who is told that nothing is "the matter." Although the patient feels

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[73] See, for example, Tom Shakespeare, *Disability Rights and Wrongs* (New York, NY: Routledge, 2006); and Rosemarie Garland Thomson, *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature* (New York, NY: Columbia University Press, 1997).

[74] The challenge of responding to suffering can be intensified by the presence of psychiatric illness. Humanism calls for greater understanding of the spectrum of variability without the imperative of creating one definition of *normalcy*. Mental illness can be a source of suffering for both the person experiencing the illness and for his or her loved ones. *Normal* has widely different meanings in different contexts and our failure to realize these differences can lead many men and women to suffer. We use *normal* as a standard for the typical, natural, expected, and harmless.

Unfortunately, as Davis and Bradley explain, expanding upon Edmund Murphy's argument, "when we make judgments about absolute goals, when we talk about what is desirable, we sometimes use the word *normal* as a synonym for 'perfection.'" Making *normal* equate with *perfection* leads to several problems. When the two concepts become tangled, and one finds one's self falling short of the standard (however it may be set), one can experience suffering. Any conception of perfection is bound by culture, context, and time. Notions of perfection can change as social expectations change, and as an ideal, perfection can never be achieved. When perfection and normalcy are conflated, feelings of inadequacy are only a short step away. We are all flawed if an ideal is our only option, and trying to live up to ideals can have severe psychological costs. According to the ideal, we all must work to better ourselves physically—be more youthful, thinner, and stronger, with whiter teeth, less cellulite, and more hair. Stereotyping becomes a danger, trying to fit the variety of humanity into only two categories: *normal* and *abnormal*. Medicine has contributed to this false notion that one can somehow attain perfect health and by endlessly pursuing an unachievable ideal, physicians become the arbiters of cultural guilt-tripping. Furthermore, those who obviously deviate from the norm are marginalized—both by medicine and society. Phillip V. Davis and John G. Bradley, "The Meaning of Normal," in *What's Normal?: Narratives of Mental and Emotional Disorders*, ed. Carol Donley and Sheryl Buckley (Kent, OH: Kent State Univ. Press, 2000), 7-16.

severe abdominal pain, the medical professionals can find nothing organically wrong. All of the best tests and tools cannot locate the source of her pain. Worse, being unable to find a problem, the physicians deem her case to be "uninteresting." Peabody laments the culture of scientific medicine that sends that patient home with a tonic and a reassuring pat that "fortunately you have not got any of the troubles [they] suspected."[75]

Writing nearly seventy years later and buoyed by the continued technological progress of the twentieth century, Cassell makes a similar critique. Physical illnesses are often highly contextual, difficult to treat, and complicated by the matter of pain. The presentation of symptoms or pain, as Cassell reminds his reader, is "irreducibly particular and individual."[76]

Often, illness announces itself in ways that resist translation. Unlike a *disease*, which signifies a physiological process within the body, *illness* signifies malaise that may or may not be associated with identifiable symptoms. The experience of illness is more personal. The person becomes aware that something is amiss within his or her body, but cannot distance the self from the body in such a way that renders the experience decipherable. Philosopher Elaine Scarry's seminal work *The Body in Pain* lays out an argument about ways in which physical pain actually creates a foundation for an understanding of the world. Scarry uses the structure of torture to explain the way in which a prisoner's world and language are unmade. Through the connection of pain's ability to ultimately deconstruct the world of the hurting person, Scarry gives further insight into the ways that pain can both contribute to and be teased apart from human

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[75] Francis W. Peabody, "The Care of the Patient," *Journal of the American Medical Association* 88, no. 12 (March 19, 1927): 879.

[76] Cassell, *The Nature of Suffering and the Goals of Medicine*, 91.

suffering. Her work focuses upon the institutionalization of pain through systematic torture, but the foundation of her argument has implications for ways that caregivers can understand the dimensions of pain and the ways that physical pain can increase suffering.

As Scarry argues, the experience of pain is in relational tension with language. Pain's power comes from its ability to impair one's capacity for meaning making by destroying language and the ability to verbalize feelings of pain. The internal experience of pain deconstructs the ability to speak when the person reverts to prelinguistic cries for expression. Likewise, the management of pain gives birth to descriptive language. To offer an example, if a heavy book falls from a top shelf and lands on my toes, I would not scream, "My toes have now begun to throb with pain." It is far more probable that I would simply yell out in a cry that has no real textual counterpart. The moments in which the most severe pain is inflicted "actively destroy language, bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is heard."[77] Only after the instant of the most severe pain has passed can a person reflect upon the pain linguistically. Sharp and throbbing both have meaning, but only from a distance from the pain's initial infliction. In describing the pain, the person attempts to distance himself from the pain by objectifying it. Embodiment, however, ensures that a space between the one who feels and the one who attempts to understand the feeling exists. Even as a person experiences the body and the pain within it as something "other," the body is ultimately inseparable from the person. We both experience and *are* our bodies.

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[77] Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York, NY: Oxford University Press, 1985), 4.

Because pain is so internal, a person can only speak of it metaphorically, and the metaphors used may not even be able to reflect the true intensity of the experience. Furthermore, how could degrees of pain, so ultimately internal, be communicated to another? Likert-type scales, which ask people to rank subjective feelings on a scale given to them (often from zero to ten), have an aura of objectivity. Such scales assume that pain can be measured. The scale, though, can be unreliable. What constitutes pain that feels like a seven out of ten versus a four out of ten is, of course, subjective. A feeling that is "throbbing" to me may feel "beating" to another. A pain's intensity and quality depend on the subject who does the rating. People experiencing pain work to make their feelings of pain understandable to one another, but pain's tenuous relationship with language makes that task exceedingly difficult. When words fail, and silence fills the space, the inability of language to capture the experience of the pain may become dominant.

Experiencing chronic pain further complicates pain's connection to suffering. The body that feels chronic pain also feels a radical disconnect from medicine's eschatological promise. Medicine's eschatological horizon remains aspirational because it remains unarticulated and unknown, and ceaseless pain undermines the vision of the idyllic future. Not only can the pain seem never ending, but it is often questioned. Arthur Kleinman writes, "If there is a single experience shared by virtually all chronic pain patients it is that at some point those around them—chiefly practitioners, but also at times family members—come to question the authenticity of the patient's experience of pain."[78] Pain, so hard to describe from the start, becomes inauthenticated by those bent

[78] Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York, NY: Basic Books, 1988), 57.

on relieving it. Physical pain then gets compounded with psychological pain. Powerless to control the pain and powerless to effectively communicate it, the person suffers.

As the medical model rightly indicates, physical pain can certainly increase human suffering, but too often medicine uses "pain and suffering" as a catch-all phrase that points to feelings that simply cannot be measured empirically. So instead, "pain and suffering" are masked with medications or patients are scanned with machines in search of some visible source. Of course, if a source of pain can be found through imaging, then treatment can be adjusted correspondingly. Finding out what hurts can be the way to alleviate some people's misery, but practitioners must be careful not to assume that by only addressing pain, suffering will necessarily be eliminated.

SOCIAL DIMENSIONS OF SUFFERING

The foregoing discussion indicates how and why suffering can have multiple root causes. People can suffer for any variety of reasons, and any number of social circumstances can create conditions for human suffering. Suffering includes the vast and complicated ways that humans can experience life's vicissitudes. The needy faces of the starving, the destitute, or the war-ravaged become a terrible blur. On the hospital wards, or even in the clinic, physicians and other members of the health-care team face the bombardment of the endless parade of human problems and vulnerabilities. The sick can lose features of identity as they become just another heart attack, just another incontinent old person in a diaper, just another nursing home patient to leave once the workday ends. Peabody interpreted this loss of identity as one of the most troubling of modern medicine's tendencies.

In *The Plague*, first published in 1947, Albert Camus describes the monotony that can accompany the practice of seeing an unending litany of sickness and death. Camus's novel tells the story of a plague-ridden North African city, but the reader can imagine how one might not need to be taking care of bubonic plague victims to feel the onus of seeing sick patients relentlessly. "Plague, like abstraction," says the novel's narrator, "was monotonous." Over and over, the physician, Dr. Rieux, has to listen to the grief-stricken cries as families watched loved ones die cruelly. He "had nothing to look forward to but a long sequence of such scenes, renewed again and again . . . Rieux had learned that he need no longer steel himself against pity. One grows out of pity when it's useless."[79]

This trend is one shared by those outside of medicine as well. As W. H. Auden writes in his poem "Musée des Beaux Arts," suffering occurs "while someone else is eating or opening a window or just walking dully along."[80] The person who suffers experiences a radical reorientation of her own life world, which becomes so small that it crowds out everything else. Meanwhile, the "dogs go on with their doggy life and the torturer's horse / Scratches its innocent behind on a tree."[81] Those who suffer continue to live in the wider world, even as they experience it closing to them.

To suffer, then, is also to be isolated, marginalized, and separated from the broader social community. Sometimes a person who is suffering is recognizable. She wears her burden in a way that others can see. Still, she may not receive the type of

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[79] Albert Camus, *The Plague*, trans. Stuart Gilbert (New York, NY: Vintage, 1991), 91.

[80] W. H. Auden, "Musée des Beaux Arts," in *Collected Poems: Auden*, (New York, NY: Vintage, 1991), 179, line 4.

[81] Ibid., lines 12-13.

moral recognition that could lessen her misery. To gaze at suffering could open one to vulnerability and to the deep awareness of our shared fragility. It is as if suffering could somehow be contagious to the other person.

Often the person experiences the anguish in silence. The suffering person may hear some attempts from others addressing her reality, but these attempts may actually worsen her feelings of isolation. She may hear someone say, "If there's anything I can do to help, please let me know." No follow-up occurs, though, for the statement was a mere show, a shadow of a demonstration of genuine solidarity. The person who blithely recognized the suffering of another makes a gratuitous gesture then turns back away. The burden of responsibility to engage in communication or human connection falls upon the suffering person. The sick person or the frail elder, made weak by ongoing misery, becomes even more marginalized by her inability to engage with those who do not suffer.

EXISTENTIAL AND RELIGIOUS FEATURES OF SUFFERING

Human suffering can be characterized in another important way often overlooked by the modern medical complex. In the earlier section on psychological features of suffering, I discussed ways that human suffering is tied to ontological and epistemological questions. The uncompromising inexorability of ongoing suffering causes many to question their fundamental beliefs about the nature of goodness and justice in the world.

The questioning of God's goodness in light of human suffering has been shared by theologians and religious persons since antiquity. The problem of evil asks how a just, omnipotent, and almighty God could let evil happen in the world. If God is merciful and

loving, then how could God let the righteous suffer? On the other hand, if God indeed allows for the suffering of innocents, then God's ultimate goodness is called into question. Christian theologians like Augustine, Martin Luther, and John Calvin attributed evil as a consequence of the fall of man into the state of sin. All three theologians believed that God created a world that is entirely good; therefore, evil stems from man's fallibility. Luther and Calvin, however, deviate from Augustine's view, arguing that God's omnipotence presupposes evil as part of a divine, overarching plan. A person may not be able understand the purpose of his *own* suffering, but he can take comfort in the faith that God's master plan is ultimately good for humanity.[82] For the person experiencing existential suffering, though, that comfort may be small.[83]

Experiencing illnesses, loss, and the reality of approaching death forces a person to ask the inevitable question, "Why me?" Even if the question is not framed in relationship with a creator or protector God, the question holds within it the deep mystery of the finality of death and the paradox of its ubiquity (all must die) and its singularity (I die once).

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[82] John G. Stackhouse, Jr., *Can God be Trusted?: Faith and the Challenge of Evil* (New York, NY: Oxford University Pres, 1998), 102.

[83] In 1710, the mathematician, philologist, and theologian Gottfried Leibnitz named this challenge of relating God's goodness and justice with the evil in the world the problem of *theodicy* (stemming from the Greek words for *god* and *justice*). Leibnitz comes to conclusions similar to those of Luther and Calvin. He argues that humans do indeed suffer, but only because they cannot fully understand the scope of God's good work. Evil is interpreted by humans who lack the capacity for understanding God's (fully logical) plan. Understanding theodicy helps facilitate the understanding of suffering as it relates to the loss of meaning for all those whose self-understanding, sense of value, and sources of comfort are somehow associated or grounded in beliefs of God as Creator and/or Guardian of human life. Gottfried Wilhelm Leibniz, *Theodicy,* trans. Austin Farrer (La Salle, IL: Open Court, 1988).

When death becomes more than a mere possibility, existential questions erupt. Leo Tolstoy represents the paradox well in his 1895 novella, *The Death of Ivan Illych*. Tolstoy narrates Ivan's thoughts:

> The syllogism [Ivan] had learnt from Kiesewetter's Logic: "Caius is a man; men are mortal; therefore Caius is mortal," had always seemed to him correct as applied to Caius, but certainly not as applied to himself. That Caius—man in the abstract—was mortal, was perfectly correct, but he was not Caius, not an abstract man, but a creature quite, quite separate from all others. He had been little Vanya, with a mamma and a papa, with Mitya and Volodya, with the toys, a coachman and a nurse, afterwards with Katenka and with all the joys, griefs, and delights of childhood, boyhood, and youth. What did Caius know of that leather ball Vanya had been so fond of? . . . Caius really was mortal, and it was right for him to die; but for me, little Vanya, Ivan Ilych, with all my thoughts and emotions, its altogether a different matter. It cannot be that I ought to die. That would be too terrible.[84]

The physician who understands theodicy and how her patients may attempt to make sense of their experiences of suffering may be better equipped to offer patients a thoughtful and reflective way to consider their miseries. This argument is made most pointedly by Daniel W. Foster in his fine essay on the way that physicians negotiate the realms of religion and medicine.[85] Foster presents a powerful discussion of the suffering of an exceptional physician who is aware of how illness and loss threaten a person's meaning and the degree to which these losses contribute to existential suffering. The concerns are present, whether physicians identify them or not, and according to Foster,

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[84] Leo Tolstoy, "The Death of Ivan Illych," in *Great Short Works of Leo Tolstoy,* trans. Louise and Aylmer Maude (New York, NY: HarperCollins, 2004), 280.

[85] Daniel W. Foster, *Health, Medicine and the Faith Traditions: An Inquiry into Religion and Medicine* (Philadelphia, PA: Fortress, 1982).

addressing existential concerns about feeling forsaken and unprotected are a "non-optional" role of physicians.[86]

The concerns are also present even if patients have the words to express them. Consider the example of the twentieth-century theologian C. S. Lewis, who explored theodicy in his work *The Problem of Pain.*[87] Lewis, ever influenced by the rationality elevated by his classical training and situation within the Enlightenment tradition, continues the argument made by Augustine and focuses his attention upon free-will. For Lewis, God chooses to be limited by bestowing the gift of free will on humankind. Lewis argues that the understanding of God as either good or omnipotent, but not both, attaches popular and underdeveloped interpretations onto the divine Creator. God, in God's infinite and omnipotent wisdom, created a free world and rational beings within it; however, if God took an active role in orchestrating the moves of every man and woman, no one would be free to act in it. Masterminding the actions of humans would lead us all to be robotic automatons. God's laws of the natural world include freedom of the will and subsequent competition from peoples and animals for limited resources. Because humans are free to act, they are free to compete, and competition can be managed in courteous, positive, manipulative, or terrible ways. The gamut of experiences, including pain, evil, and suffering are byproducts of God's gift to humans.

Lewis cogently analyzes theodicy in the *Problem of Pain* as an intellectual exercise, but true existential suffering is not manifest in his writing until he discusses his

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[86] Harold Y. Vanderpool recognizes Foster's insight in his article, "The Religious Features of Scientific Medicines," *Kennedy Institute of Ethics Journal* 18, no. 3 (September 2008): 211.

[87] C. S. Lewis, *The Problem of Pain*, in *The Complete C . S. Lewis Signature Classics* (San Francisco, CA: Harper Collins, 2002), 543-646.

boundless and ongoing grief after the death of his beloved wife.[88] Interestingly, in the heart of his religious crisis over his wife's death from cancer, Lewis does not even reference his earlier work in theodicy. Faced with the greatest emotional pain of his life, Lewis struggles even to find a vocabulary that could express his feelings of affliction. He says that his grief, though he is unafraid, feels like fear, but the fear is devoid of the powerful awe that he experiences when thinking about a numinous divine entity. Rather, Lewis fluctuates between disgust at himself and railing against the benevolent God he spent a lifetime defending. The theological question of theodicy is hard enough when one's life is swimming along, but it is execrable when one is in the throes of his grief. The emotional pain that Lewis experiences is caused in part by the false hopes they had for his wife's recovery. He lashes out at God as a Cosmic Sadist. Lewis cannot initially find solace in religion, because, for one thing, he cannot be sure that his or his wife's anguish will end with death. He has lost the feelings of religiosity that at one time grounded his very existence, and the loss of which causes him to suffer emotional pain so intense that it is accompanied by physical sequellae. In characterizing affliction, Soelle acknowledges that physical pain can be felt when psychological pain cannot be ignored or when social isolation tears a person away from community. Lewis's description of the physicality of his suffering shows how existential suffering can also manifest itself as bodily pain.

Beyond the breadth of Lewis's grief, the all-consuming nature of the grief becomes another source of existential suffering for him. He writes, "Part of every misery is, so to speak, the misery's shadow or reflection: The fact that you don't merely suffer

[88] C. S. Lewis, *A Grief Observed,* in *The Complete C . S. Lewis Signature Classics* (San Francisco, CA: Harper Collins, 2002), 647-688.

but have to keep on thinking about the fact that you suffer. I not only live each endless day in grief, but live each day thinking about living each day in grief."[89] Lewis's grief becomes ontologically significant, shaping the way that he interprets his very existence as someone who has spent a life studying and worshiping God. In the midst of his immense sorrow, Lewis questions the assumption that God is good. He recalls Jesus on the cross, crying to God, "My God, my God, why have you forsaken me?" from his torment.[90] "Meanwhile, where is God?" Lewis laments. "Don't come talking to me about the consolations of religion or I shall suspect that you don't understand."[91]

Lewis's giftedness with words helps him to phrase what are often silent experiences for those who existentially and/or religiously suffer. Lewis felt the social isolation of suffering, but expanded to include his relationship with the Ultimate Other. What grounded his very being left him bereft of the meaning, hope, and comfort that he had previously found within the faith of his religious system.

People need not have a tragedy of Lewis's proportions to experience existential suffering. The building up of smaller events, the piling on of chronic diseases, and the inability to escape the absoluteness of mortality can create conditions that cause a person to question the nature of her existence. As a person moves through life, always bound by the body and the relentless march of time, the chance becomes greater that she will come to a point when she recognize her coming end, held face to face with the potentiality of nothingness, an extinguishment of being. But what is this nothing? Martin Heidegger

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[89] Lewis, *A Grief Observed*, 660.

[90] Mark 15:34; Mathew 27:46.

[91] Lewis, "A Grief Observed," 666.

explores the impossibility of describing nothing in an intellectual exercise that might also serve to draw one closer to understanding sources of existential suffering and a corresponding desire for spirituality.[92] How could someone even begin to describe "nothing"? It is rejected by science as a nullity. Science turns away from the nothing, always seeking to know more and more, driving always to understand *something*.[93] Nothing always looms before us, always as a most extreme limit. None can know it, because to know nothing is oxymoronic. Thus, none can really question it. In order to question the nothing, however, one must be able to encounter it in some way. Death, the negation of being as such, is always the most extreme "not-yet," and as such, it can never be understood as an event. For Heidegger, death and nothingness become intermingled as the same thing. One can never absolutely comprehend the negation of being because persons exist in the world as beings and, similar to the theologians who recognized God's world as beyond our understanding, can only perceive part of that whole. While a person may gain an inkling of what it means to become nothing, lived existence precludes full understanding.

Those who grapple with existential suffering have been made privy to the shadow of nothingness. Heidegger describes the feeling of anxiety that grips a person when she truly confronts the potentiality of non-being, or, as Heidegger calls it, "being held out" into the nothingness. An uncanny feeling, it necessarily robs a person of speech, leaving the person incapable of describing it. How could she? She is trying to describe nothing.

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[92] As spirituality is a deeply personal phenomenon, it resists being pinned down with one definitive characterization. Rather, most understandings of faith or spirituality are contextual and somewhat individual. The basic working definition understands spirituality as a personal experience or confrontation with the ultimately ineffable otherness, in its many potential shapes and forms.

[93] Martin Heidegger, "What is Metaphysics?" in *Pathmarks*, ed. William McNeill (Cambridge, UK: Cambridge University Press, 1998), 84.

Instead, the nothing repels the person, making her feel as if she must fill the void. A person is not nothing! She is something! We turn away from the anxiety of nothingness, preoccupying ourselves with ourselves as beings.[94]

The historian of religion Erwin R. Goodenough describes the nothingness in another, equally discomforting, way. He conceptualizes nothingness as the *tremendum*—that which we fear above all other things.[95] People must stand in awe of the *tremendum* because they are utterly powerless to overcome or control it. The fear of the *tremendum*, like Heidegger's anxiety towards nothingness, drives a person to create myths that counteract those fears. People "drop curtains," distancing themselves from the feeling of sheer helplessness through the use of symbols, rituals, and metaphors. They turn to science, reappropriating technical language in the effort to understand that which resists comprehension. Science, seeking to answer the same primitive questions as religion, creates pseudoscientific myths that serve two purposes. They give people a sense of place in opposition to the *tremendum*, protecting the person from seeming meaninglessness. Additionally, the myths provide tools for a person to go and act in the world, meeting life's problems with emotional equipment. Goodenough argues that the tools—the myths, codes, rites, and rituals—are human constructs that instill meaning and significance but are ultimately illusory against that which is ultimately indescribable. The tools give the impression that the nature of the universe can be managed and

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[94] Ibid., 94.

[95] Erwin R. Goodenough, "Religion as Man's Adjustment to the *Tremendum*," in *Ways of Understanding Religion*, ed. W. H. Capps (New York, NY: Macmillan, 1972), 45. Goodenough's use of the term *tremendum* builds upon the work of Rudolf Otto, who called the numinous the *mysterium tremendum*. The feeling of apprehending the *tremendum* is uncanny and not necessarily frightening in the sense that one might be frightened by coming upon a dangerous bear in the woods. Rather, the *tremendum* is profound and inspires awe. It invokes dread, but not simply a fight-or-flight reaction.

understood through description but, in actuality, their significance stems only from people assigning meaning to them. Life, according to Goodenough, has meaning because humans give it meaning.[96] Humans, he argues, ingeniously create their own sense and purpose, but against the *tremendum*, they must face the possibility that they are completely defenseless.

Several authors recount their moments of clarity as they have shocking realizations of their own finitude. The psychologist of religion James Fowler discusses a winter morning when he was gripped with the anxiety Heidegger characterizes:

> Four a.m. . . . suddenly I am fully and frighteningly awake. I see it clearly: I am going to die. *I* am going to die. This body, this mind, this lived and living myth, this husband, father, teacher, son, friend, will cease to be. The tide of life that propels me with such force will cease and I—this *I* taken so much for granted by *me*—will no longer walk this earth. A strange feeling of remoteness creeps over me. . . . "Real life" suddenly feels like a transient dream. In the strange aloneness of this moment, defined by the certainty of death, I awake to the true facts of life.[97]

For Fowler, the real world around him bears little significance in view of the future negation of his being. In this moment, Fowler is separated from the world at hand. The taken-for- grantedness of life is exposed as an illusion. Instead, the radical isolation is what's real. The only truth is the certainty of death.

The humanist gerontologist Harry R. Moody personifies such anxiety as a "little voice" that whispers inside a person, "'Time is running out,' . . . 'A portion of my life is already over. Shouldn't things be better? Or at least *different*?'. . . *Time is running out.*

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[96] Ibid., 48.

[97] James Fowler, *Stages of Faith: The Psychology of Human Development and the Quest for Meaning* (San Francisco, CA: Harper San Francisco, 1981), xi. The italics are his.

Is this? really all there is?"[98] The literary scholar Wayne C. Booth recalls an anonymous poem written in the fifteenth century. Three verses of that poem reflect the anxiety that the previous authors have highlighted:

As I went on a merry morning,
I heard a bird both weep and sing,
This was the tenor of her talking:
Timor mortis conturbat me . . .

When I shall die, I know no day;
What country or place I cannot say;
Wherefore this song sing I may:
Timor mortis conturbat me . . .

Wake I or sleep, eate or drink,
When I on my last end do think,
For greate fear my soul do shrink,
Timor mortis conturbat me. [99]

Although the poet realizes that the world is continuing around him, he is consumed only with the thought of *his* impending death.

For those meeting the aging process head-on, paralysis in the face of this terror can exacerbate and intensify suffering. Within the recognition of impending death is the power to close off a person from her world at hand and from the life in which she still participates. When a person's faith has been shaken, he can easily feel the helplessness and powerlessness that are present in suffering. The aged are in prime positions to experience the failure of medicine's hopeful promises. No matter what tonic, therapy, or device used, eventually the elder will hit the natural limit of life. Medicine often offers

[98] Moody and Carroll, 4, 5.

[99] "Timor Mortis Conturbat Me," quoted in Wayne C. Booth, *The Art of Growing Older* (Chicago, IL: University of Chicago Press, 1992), 25-26, lines 4-15. The Latin phrase "timor mortis conturbat me" was often used in medieval poetry and loosely translates to "the fear of death disturbs/distresses/confuses me."

little or no response to the experience of the *tremendum* separate from those responses that are bound up with the eschatological narrative. Without a vocabulary for facing the *tremendum*, or a rich understanding of how medicine uses its own symbols, myths, and rituals as screens, the elder's tools for making meaning at the end of the life cycle are diminished.

The nature of suffering is systematically isolating, disconnecting, and marginalizing. It leaves the person feeling alone, struggling to make meaning in a land that has fully rejected him at the worst and subtly but methodically devalued him at best. Medical professionals who focus only on the eschatological promises of medicine invoke the ideal of alleviating suffering, but without examining the topology and potential sources of suffering, they can inadvertently compound and intensify their patients' suffering.

The next two chapters will examine the development of the eschatological narrative within the discourse of modern medicine and the ways that narrative came to influence the development of gerontology and geriatric medicine. The rise of specialized medical attention for the elderly has led to significant health improvements for this population. Elders experience decreased disability and increased longevity, thanks to the impressive work of gerontologists and geriatricians. Hospital Acute Care for Elder Units (ACE Units) have developed to provide sophisticated, interdisciplinary care of the elderly, utilizing the talents of physicians, nurses, physical therapists, nutritionists, and social workers. This ordered and integrated approach manages the elder's physical

symptoms and ensures that the elder has proper social support in the home after discharge. ACE Units have become paragons for quality care within the hospital.

Geriatrics and gerontology, however, are not immune to the powerful influence of medicine's eschatological vision. The specializing of elder care has become but another incarnation of the eschatological narrative in medicine. In the next chapter, I will examine more deeply the articulation of the eschatological narrative, as physicians in the late nineteenth and early twentieth centuries describe their hopes and expectations for the future in the pages of the *Journal of the American Medical Association*. Alongside the cycle of promise and fulfillment, I examine the development of geriatric medicine and gerontology in light of the medical eschatology. Though they have made great inroads, geriatrics and gerontology have often fallen prey to the eschatology's inability to deliver its redemptive promises, and as it does so, elder suffering can intensify.

CHAPTER 3: THE EMERGENCE OF MEDICINE'S ESCHATOLOGICAL NARRATIVE

INTRODUCTION

The previous chapter examined eschatological narrative's inability to address and understand the wide varieties and components of suffering. Elders, in particular, confront the limitations of the narrative claims, as, bound by time and the body, they move closer to the end of the life process. Practitioners, scholars, and activists of aging have carefully delineated the difference between disease and natural aging, creating categories of aging whose purpose is to maximize quality of life and minimize disability for as long as possible. Within the limits of these categories, *gerontology*, the study of aging, and its corresponding medical specialty, *geriatrics*, are considerably thoughtful about suffering.

Despite these strides, I contend that American geriatric medicine still functions within a milieu that authorizes the eschatological narrative and its overreaching, unfair expectations of cure and prevention. These expectations place constraints on practitioners and demands that they attempt to deliver upon the promises made by the narrative, even if the method of delivery causes more harm than it does good. Geriatrics and gerontology have been sensitive to the failure of the various immortality projects of medicine but have not been able to fully relinquish them. Without a broad vocabulary for addressing the multiple ways that elders can suffer, practitioners become pressed to the proverbial wall, having only the false eschatological hope of increased medical interventions to offer their patients in response.

The success of the eschatological narrative makes the story difficult to relinquish or even revise. The story has become entrenched within medicine's social imaginary and exerts influence upon decision making even though the narrative itself goes now largely unrecognized. As Osler's lay sermon indicates, in previous years, the narrative was invoked in more explicit ways. In this chapter and the next chapter, I examine historical sources to demonstrate how the eschatological narrative came to take hold within the discourse of modern American medicine, and how the narrative came to influence the development of modern medical care of the elderly.

I look to primary sources that reflect wider conversations between practitioners and physician-scientists in the late nineteenth and early twentieth centuries, but this chapter is not an exhaustive cultural history of either geriatrics or gerontology. By examining the *Journal of the American Medical Association* and, to a lesser extent, subsequent journals and current web pages of geriatrics, gerontology, and prolongevity efforts, I call attention to ways that the promises of medicine's eschatological narrative, as articulated in the late nineteenth and early twentieth centuries, have continued to influence the mutual expectations of practitioners and patients. I examine certain cultural moments and examples that fostered medicine's ability to untether aging from earlier meanings and interpretations because of the power exerted within the claims of the eschatological narrative. This chapter and the next contribute to other historians' work demonstrating the medicalization of aging by revealing the impact of the eschatological narrative upon the ways that practitioners interact with elder patients.

My research reveals two broad rhetorical shifts that occurred in the United States roughly at the end of the nineteenth century and through the first third of the twentieth

century. These shifts resulted in the eschatological narrative operating in two similar, but not identical, iterations. The first shift solidified the eschatological narrative and brought the old body under the medical gaze. As physicians grew more confident in what they could achieve clinically, they turned their attention toward describing the aging process and its corresponding illnesses. The study of prolongevity developed as a scientific and medical research interest as physicians imagined new methods for "curing" death.[100]

The second shift, which I will discuss in chapter 4, began later but overlapped with the first. As physicians sought to understand and push the limits of the life span, other physicians became more reticent about accepting the boundaries of limitations to medical knowledge. Realizing the hubris of trying to master death, these physicians nevertheless operated in accord with the eschatological narrative. The narrative continued to push a certain kind of care. Though death might not be mastered, research could work to ensure that diseases and disability would be so carefully managed that death would be easy, and the dying process would be free of suffering. Suffering, within this framework, is conceptualized in an impoverished way: as pain that can be managed, as psychological distress that can be medicated, or as something beyond the required care of the medical team. Because a mystery of such depth hinders the forward momentum of the story, suffering must be confined within the eschatological narrative's narrative boundaries.

The beginning of the story of medicine's increased authorization to treat, manipulate, and otherwise control bodies is not identifiable in a specific sense. One could convincingly argue for a number of overlapping beginnings, and I shall leave that

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[100] See, for example, Gerald Gruman, *A History of Ideas about the Prolongation of Life* (New York, NY: Springer, 2003).

discussion to scholars of history.[101] From the Renaissance onward, scholars, practitioners, and lay people alike gained increasing access to the study of the natural world. Within medicine, many mysteries of the human body and disease were opened and revealed to the scientist and physician. From specific, symptom-driven therapies that were tailored to the individual, physicians began to think of diseases as discrete, universal entities within a body. The drive for facts, understanding, and unimpeachable knowledge fueled the belief that the world's mysteries could be uncovered through careful observation and study. The expectation that mysteries were problems waiting to be revealed and solved came to be an important claim within the eschatological narrative. The claims of the eschatological narrative within medicine became thinkable because of the epistemological shift that occurred in the nineteenth century.

Prior to the mid-nineteenth century, visible, observable symptoms directed assumptions about disease processes.[102] Disease was primarily understood as a systemic imbalance; therapeutics were designed to help restore homeostasis. The concept of corporeal balance and its restoration figured heavily in early nineteenth-century medical practice. A person's own natural state was believed to be highly individualistic and particular; treatment, then, was to be tailored according to a person's idiosyncratic needs.

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[101] Several historical moments are worth mentioning, including Vesalius' sixteenth-century book on human anatomy, *De Humani Corpori Fabrica;* Lanneaec's seventeenth-century invention of the stethoscope, which allowed physicians to hear ausculatory sounds from a distance; or van Leeuwenhook's eighteenth-century improvement of the microscope and his discoveries of microorganisms. An interactive website allows users to access Vesalius' text: Daniel Garrison and Malcolm Hast, *De Humani Corporis Fabrica | On the Fabric of the Human Body | Andreas Vesalius*, March 19, 2003, accessed May 5, 2014, http://vesalius.northwestern.edu/.

[102] John Harley Warner, "From Specificity to Universalism in Medical Therapeutics: Transformation in the Nineteenth Century United States," in *Sickness and Health in America: Readings in the History of Medicine and Public Health*, ed. Judith Walzer Leavitt and Ronald L. Numbers (Madison, WI: University of Wisconsin Press, 1997), 87-101.

This process was incredibly intricate, as every patient was subject to a myriad of outside influences that acted upon the patient, rendering each pathological manifestation unique. To these pre-nineteenth-century healers, the body worked in dynamic relation with the natural and social world around it.[103] By the early nineteenth century, physicians had greatly refined their therapeutic process of maintaining equilibrium. The metaphor of the connected body had significant implications for the way in which healers directed their therapeutics. The body was understood to be unified and connected, and physicians believed that one condition could be based upon the symptoms of another. Physicians followed what Warner calls a "principle of specificity," which demanded that doctors keep any number of a patient's aspects of personhood in mind through the course of treatment. Gender, social status, ethnic group, job, mental constitution, and geographical location could all factor into a treatment plan. Knowledge about disease states was local, particular to the patient, and contingent upon a patient's own needs for restoring homeostasis. Warner argues that the principle of specificity had the effect of rendering disease-specific treatment illegitimate.[104]

By the latter third of the century, though, the principle of specificity was increasingly replaced by a new form of clinical cognition.[105] Several cultural forces contributed to this epistemological shift. Therapeutic treatments at the time ranged from the mild to the heroic and severe. By the middle of the nineteenth century, a debate had

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[103] Charles E. Rosenberg, "The Therapeutic Revolution: Medicine, Meaning, and Social Change in Nineteenth-Century America," *Perspectives in Biology and Medicine* 20, no. 4 (Summer 1977): 485–506.

[104] Warner, 89.

[105] This shift was an effect of several forces: diminished reliance on heroic treatments like severe blood lettings, an increased faith in the healing power of nature, and the development of skeptical empiricism.

emerged. Some physicians and lay people questioned the efficacy of treatments, especially heroic treatments. Some of those harshest critics adopted the idea of therapeutic nihilism, which rested at the opposite end of the treatment spectrum as an attractive and empirical alternative to the severe blood lettings and emetics of heroic medicine. Therapeutic nihilists believed in the healing power of nature. For these practitioners, balance was restored not by the violent depletion brought about by lets or purges, but by stimulating the system in a way that supported the body's vital energy until nature could do its work.

In between the bookends of heroics and nihilism were many options that offered the sick an array of philosophies of health and subsequent therapeutic options. The regard for heroic therapies significantly diminished throughout the nineteenth century, and different sects of practices and treatment philosophies filled the resulting gap. The various choices found in the competitive medical marketplace of antebellum America all contributed to a broad sense of pessimism among physicians, who recognized the real limitations of their therapies.

The year 1865 saw the publication of Claude Bernard's seminal text, the *Introduction to the Study of Experimental Medicine*.[106] Warner writes, "According to the 'physiological method,' experimentation in the laboratory would elucidate physiological processes in health and disease as well as the actions of remedies."[107] This concept was not entirely new to physicians, but as the knowledge base of physiological processes determined within the laboratory grew, physicians began to conceptualize disease in new

[106] Claude Bernard, *Introduction to the Study of Experimental Medicine*, trans. Henry Copley Greene (Mineola, NY: Dover, 1957).

[107] Warner, 93.

ways. Research and experimentation in physiology demonstrated not only processes of the body, but also the ways in which therapeutics altered those bodily processes. "Physiological therapeutics sought to elevate therapeutic knowledge to a fundamentally new epistemological category," Warner argues.[108] In the latter years of the nineteenth century, rationalism, and not just the empirical observations that happened at the bedside, gained authority among doctors. The principle of specificity was supplanted by therapeutics directed by the experimental sciences.

With this change in ways of knowing and approaching the sick body, physicians' objectives also changed. Observation and experimentation led to better diagnostic tools and more sophisticated systems of disease classification. The therapeutic goal of restoring balance and bringing the sick body back to its "natural" state of homeostasis gave way to the different goal. Healthiness became increasingly understood as in accordance with a set of experimentally defined parameters. These parameters marked what was considered to be "normal." Disease, then, was understood not as *unnatural*, but as *abnormal* processes or entities within the body.[109] The principle of specificity, which focused on the forces that pushed the body out of balance, moved to one of universality, in which physicians worked to move toward certainty and mastery of *any* body, regardless of a person's particular idiosyncrasies.

The pessimism that physicians felt in the middle of the century gave way to a sense of strong optimism for what could be achieved by this novel way of interacting

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[108] Ibid.

[109] Thomas R. Cole, *The Journey of Life: A Cultural History of Aging in America* (Cambridge, UK: Cambridge University Press, 1992). Cole writes, "Not until the late 1920s did medical and scientific writers begin to realize that both cultural norms and statistical generalizations were built into the ambiguous concept of 'normal'" (200).

with the bodies of sick patients and dealing with disease. Historian Thomas R. Cole notes that the shift brought about by the hope of control extended to those who were aging. He writes, "Taken broadly, advice about aging in the nineteenth century underwent a shift from consolation and mystery to exhortation and mastery—what a later era might label from pessimism to optimism."[110] Physicians felt encouraged and hopeful about what physiological medicine could achieve, and the vast developments of therapeutics in the subsequent century validate these hopes. In order to address suffering, however, other consequences also require examination. The development of the eschatological narrative, made manifest in the promise of restoration via the control of the body, is one of the consequences of such optimism. The diminished importance of the patient narrative is another consequence. Since the focus turned from the particular of a patient's circumstances to the impersonal disease-specific states, the patient's story became less important as compared to the quantifiable tests that showed observable signs of disease.

This transition is also important for understanding how the very act of becoming old came to be another solvable problem. For the purposes of this dissertation, I have explored the development of the eschatological narrative within the pages of the *Journal of the American Medical Association*, which was first published in 1883, in the midst of this epistemological shift. The journal gives a specific body of texts by which the reader

[110] Cole, 67. According to Cole, the first self-help manual on aging was published in 1829. By 1852, *The Aged Christian's Companion*, by the Reverend John Stanford, was in its third edition. The book is not specifically medical in nature; it advises on particular attitudes that the elder, defined biblically as those three score and ten or older, should maintain: "Stanford argued that gratitude, humility, and hope were the appropriate attitudes for old Christians completing their earthly pilgrimage." Cole also notes that Stanford offers solace to the aged, directly addressing the challenges of later years even as he acknowledges the firm boundaries of the life span. Though Stanford writes these consolations to help elders cope with the vagrancies of age, the idea of fashioning the work as a self-help manual is telling of the changing times.

can track the elder body's relationship to medical optimism and the ideals of progress, management, and control, and I shall use the journal as a representative example of the broader conversation.[111] Though some may argue that this journal is too narrow a sample, the journal is now, and was then, a highly respected publication for the communication of medical research and ideas by physicians to their fellow colleagues. Because of its prestige and longevity, its articles are roughly indicative of the general medical discourse at any given time and for this chapter's focus it shall serve as a surrogate for the wider body of medical literature. The development of the eschatological narrative coincides, intersects, and influences the development of medical attitudes towards aging. Some of the data speak to the rise of the narrative generally, while other data show how the eschatological narrative affected the development of gerontology and geriatrics proper.

At the beginning of 1890, an editorial in the *Journal of the American Medical Association* announced with optimism its goal for the year: "The year 1890 should show great strides in bacteriology and preventative medicine, and the unfolding of many of nature's secrets. Let scientists' word, resting assured that time will do justice to all, and that medical science will place her laurels where they belong."[112] Physicians were discovering that the empirical study of anatomy and pathology, observation of health and disease states, scientific experimentation, and aseptic medical technique were yielding recognizable treatments and cures for sick patients. No wonder the hope prevailed that,

[111]The *Journal of the American Medical Association* did not officially come to be known as *JAMA* until 1960. For sources that predate 1960, I will observe the historical name of the journal.

[112] "The Microbe," *Journal of the American Medical Association* 14, no. 2 (January 11, 1890): 59–60.

in time, the entirety of the human form down to its most minute processes could be revealed.

The May 1890 President's Address at the national meeting of the American Medical Association also reflected momentum, progress, and liberation: "The tearing off the shackles that impeded commerce and human movement in passed time, is due to medical science as applied to hygiene and this long before the amazing discoveries in bacteriology of to-day, which have given a scientific demonstration of the correctness of methods already formulated, the result of experimentation and observation."[113]

In June of the same year, an editorial argued for the strong scientific nature of medicine, seeking to distance medicine from the smell of overt religiosity. The author writes, "The age of religious discussion and dissention has left its traces in the topography of our profession and especially in the minds of the common people. But at the beginning of the eighteenth century the impulse of great scientific awakening found its strongest ally in medicine." The author shies away from calling medicine a pure science, but strongly claims that medicine is the "most scientific" of all the professions: "Medicine is the focus of scientific thought and energy. . . . To assert that medicine is not to-day and in these United States the most scientific of the professions, is to voice a depth of ignorance of what science and medicine are, which is incompatible with an unprejudiced and enquiring mind."[114]

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[113] E. M. Moore, "The President's Address. Delivered at the Forty-First Annual Meeting of the American Medical Association, Nashville, Tenn., May 20, 1890," *Journal of the American Medical Association* 14, no. 21 (May 24, 1890): 737–746.

[114] "For the Good Name of Medicine," *Journal of the American Medical Association* 14, no. 24 (June 14, 1890): 869–870.

The expectation of salvation by the wonders of science figures heavily into the 1895 Address of Welcome to the American Medical Association National Convention in Baltimore, Maryland. The address draws deeply on religious language, appropriating biblical quotes and images to further the salvific, eschatological, but secular ideals of late nineteenth- and early twentieth–century medicine. The speaker, Dr. Chew, might have told his audience from what text he drew, but the subsequent publication of his address offered no citations.[115] For example, he directly quotes John 10:10, using words attributed by the gospel writer to Jesus, and then asks, "What are the great objects to which our medical science is devoted? Are they not these? First, on its practical side, briefly this—'that they may have life, and have it more abundantly.'"[116] Chew elaborates these goals, again adopting the language of the Gospel of John, but in different chapter and verse: "The prolongation of life, the mitigations of the evils of life, the assuagement of the pains of life, are what it seeks to accomplish. And on its ideal side it has no other object than the search for truth—the pure and perfect truth . . . it seeks for truth and for truth alone in the spirit of the great words, 'The truth shall make you free.'"[117]

In the biblical context, the "freeing truth" is the knowledge and faith in Jesus as Messiah. For Dr. Chew, the truth comes not from a supernatural source, but rather from the advancements of medical science and the careful application of reason in studying the

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[115] "Address of Welcome, to the American Medical Association, at the Meeting in Baltimore, May 7, 1895," *Journal of the American Medical Association* 24, no. 22 (June 1, 1895): 828–829.

[116] John 10:10 says, "The thief comes only to steal and kill and destroy. I came that they may have life, and have it abundantly." in *The New Oxford Annotated Bible with the Apocrypha, Augmented Third Edition, New Revised Standard Version*, ed. Michael David Coogan, Marc Zvi Brettler, and Carol Ann Newsom (Oxford, UK: Oxford University Press, 2007). All subsequent Biblical quotations come from this edition.

[117] John 8:32 says, "And you will know the truth, and the truth will make you free."

natural world. The New Testament frequently uses images of light and darkness to symbolize knowledge and ignorance; Chew also uses these metaphors to discuss the promise of medical achievement: "Epidemic diseases, the nature and origin of which are involved in obscurity, the pestilence that now 'walketh in darkness,' will be set in clear light, to be blotted from the sum of human ills forever."[118]

Chew's vehicle for achieving the promises of the eschatological narrative is through the improvement of medical education. He says, "All these gains which the future may have in store, and countless others of which we now do not even dream, will be the results of higher medical education." As a rhetorical device, he exposits a list of marvelous recent medical accomplishments that are sure to buoy the optimism of the audience—a device that will be used again and again to demonstrate the value and importance of medical research. Chew saves his most important example for last:

> In that long and blessed peace which our country has enjoyed, how great are the advances which medical science has made. And perhaps the greatest of these advances—greater than the discoveries of specific methods of treatment, though these have been great and most important;—greater than antisepsis and antitoxin, and the other additions to our therapeutic resources, though these have been numerous and most beneficial;—greater than the devising of operative procedures which thirty years ago were hardly dreamed of, but which have already added thousands of years to the general sum of human life;—greater than any of these, "by the all hail hereafter," because having the "promise and potency" of results exceeding any that have yet been achieved, is the standard of medical education.[119]

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[118] "Address of Welcome, to the American Medical Association, at the Meeting in Baltimore, May 7, 1895," *Journal of the American Medical Association,* 829.

[119] Ibid.

With so many achievements within the grasp of physicians like Chew and with eyes toward an improved medical education, what could stop physicians from conquering all that was still unknown to them?[120]

Three journal issues later, Dr. Julius Kohl published an article comparing physicians of the past, present, and future with particular focus on their social positions.[121] He praises the work of physicians and believes that their social standing should be exalted: "Our calling . . . is an exalted vocation. The unsullied position of the physician should tower high above his other achievements."[122] Kohl is particularly excited about the current state of medicine as compared to the medicine of history: "at best, the practice of medicine during the three hundred years preceding the present century was a mixture of science, theology, astrology, magic, witchcraft, superstition, spiritualism and a mass of other indescribable 'isms. . . . The last fifty years must be

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[120] This form of listing past achievements in order to justify the promises made for the future would occur several times in the coming years. In 1935, an elder in the field of internal medicine gave remarks on its development since the turn of the century. Like Dr. Chew's speech forty years prior, Dr. Herrick's speech gives a sparkling listing of exceptional medical accomplishments wrought in only a generation. He discusses the development of bacteriology; knowledge, treatment, and prevention of a catalogue of infectious diseases; the rise of X-ray technology; and other instruments useful in diagnosis and treatment. Herrick looks at current strides being made in blood chemistry and deficiency diseases: "This order [that a physician makes for a patient's blood chemistry] is issued not merely to satisfy an academic curiosity; it is realized that it may disclose diabetes, uremia, or hyperparathyroidism."

At the end of his talk, Herrick looks simultaneously to the past and future. He says, "Some of us of the passing generation may wish that we were young so that we might take part in the advances of the future, the solving of the riddles of cancer, endocrines, infections yet untamed or even unnamed, degenerative vascular disease. But with an *ave et vale* we may retire content, assured that internal medicine of the future, in its research, as in its practice, is in safe hands; knowing that when another generation has passed and there is held the seventieth anniversary of the Section on Pathology and Physiology, glorious achievements of the preceding generation will be recounted and that then, as now, a glorious future will be predicted." James B. Herrick, "Changes in Internal Medicine since 1900," *Journal of the American Medical Association* 105, no. 17 (October 26, 1935): 1312–1315.

[121] Julius Kohl, "The Physician of the Past, the Present, and the Future—A Definition of His Social Position," *Journal of the American Medical Association* 24, no. 25 (June 22, 1895): 966–971.

[122] Ibid., 966.

credited with having given to the world the exact sciences of medicine and surgery, and their emancipation has been completed."[123]

By conceptualizing medicine and surgery as "exact sciences," Kohl bestows an immense power upon the physician; indeed, he claims for the physician "the whole earth and its surroundings." He writes:

> Medicine and surgery are recognized by the entire civilized world as independent sciences, and we, their disciples being entrusted with their care and application have assumed, as the physicians of the present day in this immense field, the greatest of obligations and responsibilities. We have at our command the whole earth and its surroundings, and have the right to press all into our services, but with these rights are manifold duties.[124]

The power of the practitioner of 1895 elevates Kohl's physician to a particularly high status. "What has the physician to do with the great social questions?" Kohl asks. "I answer, his relations to such questions place him on a footing equal to, if not above, that of the spiritual adviser."[125] Kohl gives three primary reasons to support this claim. First, physicians are in close, daily contact with men. Second, through their training and practice physicians come to possess superior knowledge of nature and the natural world. This sort of knowledge works in tandem with Kohl's third reason to elevate the physician to the role of a secular shamen. Kohl, displeased by the spectacles of traveling religious revivals, writes that the Church has lost its authority and has become merely empty entertainment. For Kohl, religious authority may be waning, but the authority of the physician is on the rise because the physician is "girded with the armor of the never-

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[123] It is interesting to note the organic, fluid description of science and its connection to medicine. This author calls medicine and surgery "exact sciences" while the editorial in 1890 advocating the good name of medicine called medicine the "purest of the sciences."

[124] Kohl, 968.

[125] Ibid.

erring laws of nature . . . ready to fearlessly take up the gauntlet against any antagonist."[126] Spiritual leaders still had enough social recognition that Kohl wanted to associate physicians with them, but he wanted to place physicians even higher because they relied not on mystical knowledge but hard, empirical truths of nature.

THE FIRST SHIFT: THE ESCHATOLOGICAL NARRATIVE AUTHORIZES MEDICINE TO TREAT OLD BODIES

During this time of great optimism, physicians could not extend much medical optimism to the elderly, but the hope and promise of the eschatological narrative would come to be available to the aged. The promise of health and increased youthfulness had to be extended to those over the age of sixty-five because of the new way in which Americans were coming to interact with those men and women. I shall turn to historian Carole Haber's work to help explain why the eschatological promise held in it such importance for those treating elders. Haber tracks how the term *old* came to be socially differentiated as a descriptor for those over the age of sixty-five within America.

While such a classification, though troublesome, is commonplace in American today, Haber demonstrates that this distinction was not always assumed but rather emerged as a result of shifting cultural factors. She argues that, by the early twentieth century, elders came to be stereotyped within society as superannuated and needing to be marked as different from the rest of society. The new classification of *old,* was based upon the assumption that senescence "was a distinctive and debilitated state of

[126] Ibid.

existence."[127] "The nineteenth-century measures that defined and limited the roles of the old," Haber writes, "were based on a transformation in the way society attempted to eliminate disease and dependence."[128] From the family structure to medical care, prior to the nineteenth century, those over the age of sixty-five were not really marked out as different simply because of their chronological age. Her work reveals how the aged came to be made more invisible within American society through the changing structure of the family, bureaucratic measures like imposed retirement, and institutionalization into old-age homes.

Prior to the shift in the nineteenth century, elders held a more integrated role within society. Haber argues that in colonial times, fewer men and women reached advanced years, so these people, for better or worse, were more visible within their communities. In distinction to the modern idea or even expectation of retirement, senescence was a time of activity for many elders, though the experience of being aged varied between individuals. The structure of the family, maintenance of productivity, and land holdings all worked to keep elders within the public eye. The colonial family makeup was such that grandparents often remained heads of households. It was not uncommon for a woman to bear children across a fifteen- to twenty-year span; her youngest child could likely be close in age to her first or second grandchild.[129] Parenting duties kept elders, both male and female, as important members of the family. For men, remaining the head of the household contained rights and responsibilities. Even after

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[127] Carole Haber, *Beyond Sixty-Five: The Dilemma of Old Age in America's Past* (Cambridge, UK: Cambridge University Press, 1985), 5.

[128] Ibid.

[129] Ibid., 11.

their sons were grown, men found interest in remaining household heads so that they could maintain control over land and assets and influence marital choices and timing of their children. Haber writes that those elders without land, familial duties, or wealth could be pitiful and in need of charity.

In the nineteenth century, two major contributors were responsible for the changing perceptions of elders. First, the economic landscape changed. Urbanization and industrialization changed the relationships that parents had with children. Birth rates declined across the century, and women became more likely to complete their child rearing with years of life left. By 1910, Haber writes, "this empty nest syndrome had become the familiar condition of nearly one in four."[130] For men, living without households to head meant loss of security and a guaranteed sense of placement within the life cycle. Once the children had left the household, a person was more readily identifiable as old. Furthermore, as people moved into big cities, older men and women had less control over land. Though men and women were still judged by their ability to remain productive, sources and reasons for productivity were diminished. Employment opportunities during the nineteenth century also lessened, and those positions that remained held less prestige.[131]

Second, the rise of social work had direct implications for how the elderly were treated. In the latter third of the nineteenth century, social work began to develop in concert with the development of "scientific charity." Recipients of that charity included the destitute, and social workers who engaged with the elderly did so primarily with those

[130] Ibid., 29.

[131] Ibid., 33.

who were poverty-stricken and otherwise needy. Because the social workers were engaging with the most vulnerable of the elder populations, the social workers' perceptions were skewed. Negative perceptions of the old influenced philanthropy and charity assistance. Haber writes that social workers, in their writing, "presented a persuasive view of senescence that emphasized its weaknesses and problems. . . . As a result, their characterizations of needy old age, although exaggerated, reflected their daily experience with the elderly."[132]

She notes that both social workers and physicians of the nineteenth century focused upon infirmities and weaknesses, which reinforced negative stereotypes of elders. Old age, which prior to the nineteenth century had been considered in developmental terms, was recast as pathological. In colonial America, physicians treated the old and young in similar ways, but as the nineteenth century progressed, aging was configured as a pathological process that needed the care of the physician. "Simply put," she writes, "all persons who had grown old were likely to exhibit signs of decay. Thus, in medical and sociological terms, at least, old age was a time when separation from society was both necessary and desirable."[133]

In order to fit within the eschatological model of promise, fulfillment, and the desire for a good old age, the negative consequences of aging had to be configured as pathological. Writes Cole, “old age was removed from its ambiguous place in life's spiritual journey, rationalized, and re-defined as a scientific problem."[134] Conceptualized

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[132] Ibid., 35.

[133] Ibid., 81.

[134] Cole., xx.

as unnatural and wrong, the "problem" of aging could become a solvable entity. Promises of delayed decline and increased fitness could be made, all in the hopes of mastering the failing body. These promises, however, contributed to a sterilized understanding of becoming old that whitewashes multiples sources of elder suffering and the multiple, often conflicting meanings of age.

The earliest volumes of the *Journal of the American Medical Association* did little to actually address the medical problems of the elderly. The first mention of elders in the journal comes in the third volume as a bit of amusement when readers receive a little blurb about Sherlock Holmes: "Dr. Holmes has recently been moralizing over length of days as the reward of correct living. He is reported to have said that 'Death to the aged man wears as pleasing a face as sleep does to one who is tired.'"[135] The choice of inclusion demonstrates what Cole describes as the sentimentalized view of "civilized" aging: "By the middle third of the nineteenth century [the system that held conflicting views of age in tension] was unraveling. An expanding society, committed to ever greater quantities of health and wealth, found it increasingly difficult to acknowledge . . . the complex and unmanageable dimensions of aging. One's physical, material, and spiritual condition in old age had become solely a matter of individual responsibility."[136] These Victorian images propagated the notion that illness was caused by personal failure and health was a reward for right living. Sentimental images of age, like that proposed by Doyle's Sherlock Holmes, "provided a cloudlike sanction that helped to preserve important ideals, goals, and conventions of aging. Behind the mist stood a compelling

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[135] "Preliminary Arrangements," *Journal of the American Medical Association* 14, no. 3 (January 18, 1890): 98.

[136] Cole, 140.

ideal of 'civilized' old age—an ideal that often diverged from its sentimental legitimation."[137] This civilized old age did not include the multiple meanings of aging, the contingencies and limitations inherent in the process of physical decline. The individual responsibility of attaining a "good" old age was bound within maintaining physical health, productivity, and self-reliance. "Bad" old age, with disability, disease, and dependency, was marked as personal failure.[138]

The *Journal of the American Medical Association'*s first article specifically discussing causes of old age was published in 1895 as an editorial, but it references an earlier discussion by physicians who tried to find one source of the aging process. The author first debunks the "pseudo-scientific paragraph" in which scientists argued for one particular bacillus that induced old age but goes on to argue for the truth in the desire for a "theory to account for some of the symptoms of old age."[139] The desire to locate a particular cause of old age tied in with the rise of the new physiologic medicine. The author places the blame of age upon germs: "The microbes of old age are all the disease germs that attack vitality, either consciously in actual disease or through the slow and by us almost unfettered sapping of the system in a thousand different ways which they must be constantly effecting at every point of least resistance."[140] Recognizing that science had not yet achieved the goal of determining the root causes of old age, the author still makes a claim that aging is at least somewhat unnatural and could be postponed with the

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[137] Ibid, 145.

[138] Ibid., 161-162.

[139] "The Causes of Old Age," *Journal of the American Medical Association* 25, no. 25 (December 21, 1895): 1101–1102.

[140] Ibid., 1101.

correct combination of hygiene and treatments of microbial sources of aging. He writes, "The truth probably is that most of us grow old too fast, that by our own fault or that of our progenitors, we yield too soon to the microbes and toxins that hasten on old age."[141]

A short note filed under "Miscellany," in 1899, describes another dream of discovering a microbial source of aging, as well as being able to eradicate said microbe. The short entry, under the subheading, "Senile Microbio-Mania," states:

> The *Revue de Thérapeutic* says: A savant of Naples, Dr. Malinconico, has made a greater discovery than the famous elixir of youth of Brown-Séquard. The journals announce very seriously that Dr. Malinconico is about to discover the microbe *of old age*. . . . The microbe is transmitted, according to the Italian savant, by inheritance, invades with age the entire human organism, ravages and destroys it, producing old age, and finally death. . . . Dr. Malinconico hopes that he will be able to discover the means to combat, and finally to destroy, this terrible microbe, which will prevent men from growing old. The savants are invaluable.—*Times and Register*[142]

Jean Martin Charcot's book *Clinical Lectures on the Diseases of Old Age*, the primary geriatric text from 1881 until 1914, presents physiology as the means for moving toward medicine's Valhalla. In the preface to the book, Charcot "boldly asserts" that the future of medicine will be revealed through the study of physiology, which he calls timeless, unchanging, and without mystery. The only mysteries are those which have not been uncovered by the researcher.[143] Charcot says:

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[141] Ibid., 1102.

[142] "Miscellany," in *Journal of the American Medical Association* 13, no. 12 *(*September 21, 1899): 432. A subsequent search of Malinconico's name revealed no other contributions by the Italian. The "famous elixir" to which this story alludes was a combination of animal sex glands extracted and injected by Charles-Édouard Brown-Séquard, neurologist and successor to Claude Bernard as the chair of experimental medicine at the College de France. His announcement that he had rejuvenated himself caused a bright burst into the media, but after the initial sensation, faded away (Cole, 180).

[143] Jean-Martin Charcot and Alfred Lebbeus Loomis, *Clinical Lectures on the Diseases of the Old Age* (New York, NY: William Wood & Company, 1881) , 4.

> The new physiology still absolutely refuses to look upon life as a mysterious and supernatural influence which acts as its caprice dictates, freeing itself from all law. It even goes so far as to believe that vital properties will some day be brought over to properties of a physical order; it states, at least, that from this moment one must not establish an antagonism, but a correlation between these two orders of forces . . . It does not seek to find out the essence of the *why* of things, for experience has proved that the human mind can never pass beyond the proximate causes, or the conditions of phenomena's existence. . . . It brings to it, in reality, a method long since tested, the experimental method, that admirable instrument which in its hands has already unveiled so many mysteries.[144]

Charcot also includes in his preface a quotation that reveals his optimistic hope about what science can achieve: "The day when science shall have attained a complete knowledge of normal man, to the very depths and inmost parts of his organization, and into the most secret mysteries of his life; the day when science shall have unveiled all the secrets of the pathological condition, and understood every modification that external agents can produce in the economy—that day science will be completed."[145]

An address to the New York State Medical Association by Dr. Joseph D. Bryant, given in 1899, was published in January of 1900. He begins by offering a sort of creation story for medicine, saying that "human sympathy first prompted medical effort" and that the relief of suffering ("presumptively of the human kind") was coincident with the beginning of medical knowledge. He also addresses the drive of all of medicine; he calls the labors of physicians "begotten of a mutual participation in unceasing war against an insidious, tireless, and finally successful foe—disease—and its dread sequel—death."[146] Bryant situates the genesis of medicine with religion, but quickly highlights their divorce

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[144] Ibid., 12.

[145] Requin, quoted in Charcot and Loomis, 4.

[146] Joseph D. Bryant, "Influence of the Medical Practitioner on Medical Practice." *Journal of the American Medical Assocaition* 34, no. 3 (January 20, 1900): 127.

so that he can direct his audience toward the new ways of knowing. He says, "The advent of newer methods of observation . . . rapidly supplanted the assumption of empiricism with the rational conclusions of unerring scientific investment. The hidden mysteries of the heretofore subtle agencies of disease are now being rapidly solved by the application to their presence of Nature's similar agencies."[147]

Bryant's vision of medicine's telos is not so fervent or radical as Osler's would be ten years later, but his optimism is just as strong:

> The previous conflicts waged by man against disease in self-defense are now changed to the substantial victories of aggressive actions. Terror, woe, and sadness, the heritages of earlier disease devastations, are supplanted by confidence, joy, and gladness—confidence in the power of man to prevent, joy in the realization of the outcome, and gladness in the knowledge that misery and death are being pushed apace to the rear.[148]

Bryant, however, is reluctant to fully give way to the hope of conquering death altogether: "Man's relation to the earthly order of things forbids that this conflict shall cease or that he shall be victorious." Unless scientists discover and isolate "the bacillus of old age," men cannot hope to "establish a rivalry between human longevity and infinite time."[149] No matter, though, because confidence, joy, and gladness rule the day. Terror, woe, and sadness, surely experiences that are also part of the human condition, are not just pushed to the side in his construction of the eschatological narrative, they are indeed supplanted.

From the inception of the *Journal of the American Medical Association* until the turn of the twentieth century, correspondingly few articles addressed the problems of the

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[147] Ibid., 128.

[148] Ibid.

[149] Ibid., 129.

elderly. Not surprisingly, as the eschatological narrative became embedded the world view of modern medicine and as scientists turned their attention toward more complicated questions, the number of articles addressing old age and the elderly body grew. Historian W. Andrew Achenbaum points out that none made so bold a claim that the "ravages of age had been eliminated."[150] Still, the hope emerged that the ravages of age might one day be eliminated. The old body appeared on the physicians' horizon of study, and, naturally, the locus of the old body became another source of eschatological hope. In order to treat and heal these sick bodies, one must be able to describe them well. Over the next decades describing the physiology and pathology of aging would become the focus of many research scientists and physician-scientists.

A commencement address given in 1897 reflects the future of old age.[151] The speaker, Dr. Love, directs the listener toward a future when death shall be free of misery wrought from outside sources. Happiness will be strictly a matter of personal responsibility. Medicine will have done its work in the earlier parts of the life cycle and will have guaranteed a restful old age. Love says, "At the present rate of advancement the time will soon come when no one need die before his allotted time, save by accident. . . . if the laws of health were properly observed and there was a proper application of the definite knowledge that we now have, all of [the] deaths prior to the age of five years need not occur at all." The title, "The Needs and Rights of Old Age," addresses neither of the two; rather, it is about staving off the decrepitude of old age. In a sentiment that will be echoed by later writers, Love predicts a time when old age will not contain

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[150] W. Andrew Achenbaum, *Crossing Frontiers: Gerontology Emerges as a Science* (Cambridge, UK: Cambridge University Press, 1995), 42.

[151] I. N. Love, "The Needs and Rights of Old Age," *Journal of the American Medical Association* 29, no. 21 (November 20, 1897): 1033–1039.

discomfort. Microbes are everywhere, says Love, but we get sick at least partly because of our own "indiscretions." Thus locating sickness within the realm of personal responsibility, Love says that "it is becoming more and more evident every day that nearly all the diseases of middle and older life are interruptions in what is called metabolism, or tissue building, some break in the equilibrium of the process of nutrition."[152] According to Love, hygiene is the key to helping humans "live happy lives and progress to a delightful old age."[153] Elders should pay attention to their teeth and nutrition; women should learn to cook and cook well. Love also moralizes not on the rights of the elder, but upon the elder's duties. He adheres to the ideal of the civilized old age, constructing a fine old age as a reward for a moral life filled with productive work. Love says, "A worker in any field, whose age is near either the shady or the sunny side of fifty, should consider himself in his prime good for another half century of temperate judicious work." The happy old age will come from both work and self-awareness. The old man should "know himself now if ever and feel within himself the peace of heaven and earth, a still and quiet conscience. This has to be accomplished by a good and worthy life on general principles. He with the silvery livery of advanced age, whatever his past life has been is generally willing to be more correct, less frivolous, with a higher regard for morality, and a greater contempt for the vices of civilization, and this is fortunate."[154]

Love blends scientific progress and promise with the moral thrust of the Protestant ideal of salvation manifested through successful hard work. Even if old age

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[152] Ibid., 1034.

[153] Ibid.

[154] Ibid., 1035.

cannot be conquered now, by using hygiene to counter metabolic changes and by living a "worthy" life, then old age will be free from suffering. His goals still have a hint of epic conquest, though; Love looks ahead to the aspirational horizon when he cites Boston University Medical School physician C. A. Stephens's hopeful promise, saying that he is "convinced that the progress of brain science will enable to successfully [sic] overcome decay and its climax, death."[155]

The man whose theories most notably searched for some sort of microbial source of aging was Elie Metchnikoff. Winner of the Nobel Prize for observing, describing, and putting forth a theory of cellular phagocytosis, Metchnikoff first coined the term *gerontology* in 1904. His work demonstrates the capacity to which the horizonal hope could possess the imagination of a researcher. Metchnikoff was prone throughout his life to severe depression, but he took a decidedly optimistic tone for his study of aging. By the time that he turned his attention to aging, Metchnikoff was well established, with laboratory space given to him by none other than Louis Pasteur. His career's work spanned from studies of embryology to cellular digestion, and by the time Metchnikoff turned his attention toward aging, later in his career, his work had begun to take a philosophical bent. His book, *The Nature of Man: Studies in Optimistic Philosophy,* captured his bright hope for the future postponement of aging, disease, and death.[156]

Metchnikoff believed that the primary cause for aging was ongoing phagocytosis of tissues by macrophages that resulted in a state of chronic mild bodily intoxication (particularly in the gut). Aging, for Metchnikoff, was an entirely pathological process,

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[155] C. A. Stephens, quoted in Love, 1036.

[156] Elie Metchinikoff, *The Nature of Man: Studies in Optimistic Philosophy* (New York, NY: G. P. Putnam's Sons, 1907).

and one that scientific development and application could stop altogether. If the body could be appropriately managed and disciplined, argued Metchnikoff, it could achieve what he called an "orthobiotic" state in which people would live healthily up to the limit of the natural life span, a time that he considered to be between 120 and 130 years old. At that point, Metchnikoff believed, humans would naturally be ready to die and would pass away without remorse or grief.

In a biographical essay about Metchnikoff, R. B. Vaughan recognizes the extent to which Metchnikoff was taken by the scientific and medical eschaton. Vaughan writes, "He was completely carried away by the idea that by applying the scientific method the nature of man could be moulded in any way that seemed desirable, a sort of brave new world. The closing sentence in the book on the nature of man gives us an idea of his passionate belief in the possibilities of science for good. 'And if it is true, as is so often affirmed, that it is impossible to live without faith, that faith must be faith in the power of science.'"[157] The English editor of Metchnikoff's work, P. Chalmers Mitchell, agreed, citing Metchnikoff himself: "If it be true that man cannot live without faith, this volume, when the age of faith seemed gone by, has provided a new faith, that in the all-powerfulness of science."[158]

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[157] R. B. Vaughan, "The Romantic Rationalist: A Study of Elie Metchinikoff," *Medical History* 9, no. 3 (July 1965): 210.

[158] P. Chalmers Mitchell, "Editor's Introduction" in Ibid. Metchnikoff knew suffering. The late 1860s and 1870s were years of prolonged difficulty for him. He and his first wife were both afflicted with a respiratory problem. Metchnikoff recovered, but his wife stayed chronically ill. Metchnikoff also had a falling out with his best friend and fellow researcher. By 1869 Metchnikoff found himself with no genuine laboratory space and stultified by poverty. Metchnikoff eked out a meager salary as a translator, and he turned a room in his flat into a lab in order to teach students; however, he was unable to perform any research of his own. Four years later, in January of 1873, Metchnikoff's wife died and Metchnikoff became so despondent that he attempted to take his own life twice.

Metchnikoff's optimism could, in some part, be attributed to the mounting criticism that he faced as growing evidence opposed his phagocytic theory of aging. Achenbaum writes, "As opposition mounted, Metchnikoff became more rigid in defending his theory, more extravagant in making his claims."[159] Achenbaum also notes that Metchnikoff was somewhat revolted by old age, quoting Metchnikoff: "'Old age is repulsive at present, because it is an old age devoid of its true meaning, full of egoism, narrowness of view, incapacity, and malignancy.'"[160] Faced, however, with the inability to deliver upon the promise of immortality, Metchnikoff was unyielding and unwilling to revise the eschatological narrative as he interpreted it. In doing so, Achenbaum argues, Metchnikoff "dared to offer hope that life expectancy even in adulthood might be extended through proper hygiene as well as scientific advances."[161] Metchnikoff framed the eschatological horizon in such a way that it became accessible to scientists. Achenbaum says that "by framing his ideas in metaphors understood by orthodox scientists and the lay public alike, he made new ideas accessible. This tack furthered Metchnikoff's hopes that gerontology would become a science that 'allowed the widest and freest scope' in theory and practice."[162]

A year after Metchnikoff introduced the term *gerontology*, Dr. Charles Stockton spoke at the American Medical Association National Convention in Portland, Oregon, on

[159] Achenbaum, 28.

[160] Metchnikoff, quoted in Achenbaum, 29

[161] Achenbaum, 32.

[162] Ibid., 33.

the topic of delaying old age and alleviating senility. He does not place much value in old age, but admits that elders remain with us:

> In saying this we are not unmindful of the rightly interpreted utterance on this subject of one of our most distinguished colleagues. From the standpoint of the original investigator, as from that of the soldier, or the adventurer, there is nothing to replace the effort of the man under forty; but if for no other reason than to obstruct impetuosity and to provide such a handicap that youth shall too soon outrun the limitations which a wise Providence has provided, middle and late old age have their uses. At any rate the old man is with us and there appears to be no acceptable method of obliterating him, even if it would add to the welfare of the race to do so.[163]

Given that doing away with elders seems not to be an option for Stockton, he turns his attention to what can be done about the reality of old age. He admits, "There remains for brief consideration the question of what can be done to make old age more tolerable; in other words to remove it to a physiological basis. . . . To a few the diseases of old age have a peculiar charm, and these few who give senile diseases special study seem to agree that for the most part they arise from toxic causes."[164] Stockton locates the prospect of a better old age not in varieties of consolations or meaning making, but rather in the control of disease processes.

Following Metchnikoff's argument, Stockton claims that most senile diseases originate in the colon: "Old age is repulsive when it is pathologic, but it is beautiful when it is physiologic, and it would appear as a fitting theme for the consideration of this great body at its meeting in this new land of the setting sun."[165] He is clear that, while

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[163] Charles G. Stockton, "The Delay of Old Age and the Alleviation of Senility: Oration on Medicine at the Fifty-Sixth Annual Session of the American Medical Association at Portland, Oregon, July 11-14, 1905," *Journal of the American Medical Association* 45, no. 3 (July 15, 1905): 165.

[164] Ibid., 169.

[165] Ibid.

the scientific understanding of the physiology of aging is limited, aging is indeed pathological. He says, "For the moment it is enough to know and to recognize that senile atrophy is pathologic and that, essentially, old age is disease."[166] Stockton cannot offer much to the old person in terms of adding years to life–he extols the use of optometry, dentistry, and nutrition to slow arteriosclerosis, but he makes the point that scientific study could push the limits of the life span:

> If we are further to lengthen the probational study period in medicine, it will be wise to give the matter of deferred old age very careful consideration. If the subject were studied seriously, we would see a tremendous improvement in the type of humanity, and the readjustment of many habits, customs, social questions along altogether new lines. . . . At any rate it will be admitted that middle age could be considerably prolonged and the infirmities of old age largely mitigated if we could eliminate from the equation that faulty cell metabolism which arrives through inheritance.[167]

This "improvement" of humanity ties into the main thesis of Stockton's presentation. The talk "The Delay of Old Age and the Alleviation of Senility," and Stockton's ultimate answer for such alleviation is through eugenics. By allowing unsavory genetic strains to "blend and dilute" the stronger group, Stockton worries that the telos of the eschatological narrative will never be attained. Assuming that end is achievable, the physician laments that without the adoption of a eugenic vision, "we are unquestionably lowering the future standard of internal resistance and we are creating a threat to physical, intellectual, and moral perfection."[168] He says that "man has not the moral right

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[166] Ibid., 166.

[167] Ibid., 167.

[168] Ibid.

to beget disease."[169] Selection of strong bodies and sterilization of those who are afflicted with any variety of disease would help to "elevate man spiritually, strengthen him intellectually, increase his vital and physical vigor, thus widening the period of his usefulness and decreasing his sufferings as a whole."[170] Stockton argues that in this way healthiness would be maximized and aging would be slowed.

Achenbaum argues that the early work in gerontology was never characterized by great optimism; indeed, he describes marked pessimism in the idea of "curing" age. Stockton's limited hope for the elder is evidence that the eschatological promises were difficult to fulfill for elders. But the aspirations of turn-of-the-century physicians, scientists, and writers were stronger than Achenbaum suggests. Achenbaum references a 1906 columnist who writes, "Old age is a disease, that is to say, it is essentially a pathological condition. . . . But for it there exists no therapy, no cure." Achenbaum goes on to say, "Little wonder, then, that few expressed great optimism about the prospects of finding a scientific remedy for the problems of senescence. Those who were sanguine about something positive emerging out of gerontology in the future were in a minority, at the margins of the scientific community."[171]

"The Quest for Prolonged Youth," written by Dr. Carl Snyder and published in 1906 in the popular journal, *Living Age*, does recognizes the limitations of medicine in first decades of the twentieth century, but the pessimism that the beginning of the article suggests gives way to a more optimistic tone throughout the remainder of the article. Snyder states that "it may be that we shall never learn to avert old age . . . Whether we do

[169] Ibid.

[170] Ibid.

[171] Achenbaum, 42.

or not, it seems possible that we may at least learn its cause."[172] To open the door for this type of knowledge has implications for Snyder. Physiology was, says Snyder, "Born but yesterday" so "there is in all this little real ground for discouragement or pessimism."[173] After describing several recent discoveries of physiology in a list, he goes on to explain his intent by means of prognostication. Snyder writes, "The intent was simply to make clear how very, very new is much of our knowledge of some of the most vital functions . . . further, to enforce the obvious conclusion that much which yet remains obscure may sooner or later be clear up, among other things, old age . . . A great light may come any day."[174]

Snyder is realistic but keeps his eyes fixed on the horizon, looking forward to the future, even though he is reluctant to imagine it for his own lifetime. Snyder cites the possibility of extending human life, saying that "if Sir John Lubbock can keep a queen ant alive for two or three times its apparently natural term of existence, it does not seem impossible that we might very considerably prolong the period of human existence." Though avoiding the sweeping promises of other physician-scientists, Snyder still verbalizes the eschatological promise held in the study of physiology. He writes, "And this complete descriptive knowledge is but the prelude to the higher achievement which is the more or less conscious aim of all rational scientific investigation; this, in the phrase of one of the most distinguished of present-day physiologists, is *the control of*

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[172] Carl Snyder, "The Quest for Prolonged Youth," *Living Age,* 251 (November 10, 1906): 323.

[173] Ibid.

[174] Ibid.

phenomena" (italics are his).[175] The need for describing old age, in Snyder's estimation, is understood in relationship with the goal of controlling it.

Aging continued to be medicalized throughout the decade as physicians and scientists came to observe and describe more of the physiological and biological effects of age. Charles Sedgwick Minot pathologized aging in his 1908 book, *The Problem of Age, Growth, and Death*.[176] In the introductory letter that prefaces the book, he writes: "If one starts with the purpose of getting nearer a solution of the final problem of life, it is not difficult to devise numerous researches which would be likely to gain for us insight into the fundamental phenomena of biology."[177] Minot qualifies his work, saying that he disagrees that "age is a kind of disease," but he also says that by studying the "essential changes which are characteristic of age" he can discover generalizable knowledge that can "obtain power over age" and "the changes which the years bring to each of us."[178] Like Snyder, Minot recognizes that describing the phenomena is only the first step in being able to control the phenomena.

Those who sought to describe bodies grew ever more advanced in their descriptive and diagnostic abilities and tools. Within the pages of the *Journal of the American Medical Association* there was a marked increase in the number of articles describing the physiology of old age in the first third of the twentieth century. The link between description and control became verbalized in terms of precision. Physicians and

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[175] Ibid.

[176] Charles Sedgwick Minot, *The Problem of Age, Growth, and Death: A Study of Cytomorphosis, Based on Lectures at the Lowell Institute, March, 1907* (New York, NY: J. Murray, 1908).

[177] Ibid., xvii.

[178] Ibid., 29-30.

researchers (often one and the same, still) sought to understand a given disease process with startling specificity. The goal for the application of new technology was similar. Control of the messy body could be achieved through the exacting mastery of the details of disease.

Mans' ongoing redemption of man continued to work within the boundaries of the eschatological narrative. The expanse of hope stretched wide across the human body. One physician presented the promise of urology a site of promise fulfillment: "That urology has exercised a definite important influence certainly cannot be denied, particularly in remembrance of the fact that, in the entire realm of medicine, there is no part or specialty in which diagnosis and treatment, by virtue of new inventions and discoveries, are more precise, satisfying, and complete."[179] The doctor's focus on urology was connected with a broader discussion about immortality and its connection to medical progress: "It seems a fundamental trait of human nature to want to live as long as possible, and man and medicine have ever striven to promote the public health and lengthen the span of life." He poses the moral query, "What should be the span of life?" but his article never answers that question.[180] Rather the physician works to answer the question, "What *could* be the span of life?" with hopeful observations and extrapolations about current research. He cites that life expectancy has been steadily increasing, experiments suggest cell immortality, and that "studies with food, vitamins, and enzymes in animals indicate that the duration of life may be tripled."[181] The physician goes on to

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[179] B. A. Thomas, "The Influence of Urology on Longevity," *Journal of the American Medical Association* 86, no. 26 (June 26, 1926): 1957.

[180] Ibid.

[181] Ibid.

say that the average length of life is increasing and offers hope that the average length of life might reach seventy years within the next half-century.

Another author placed his hope in nutrition, writing, "When we have completely solved this great problem of nutrition, we shall perhaps have solved not only the problem of cataracts but the greater one of glaucoma and many other ills that the flesh is heir to, in the eye and in the entire human economy."[182] Yet another offers the promise of modern alchemy, writing, "Dr. Aston made the remarkable prophecy that the nuclear chemist will transmute and synthesize elements as his elder brother has done molecules. 'I foresee a time not immeasurably far distant, when it will be possible for us to synthesize any element whatever, wherever, and whenever we please: alchemy indeed in the service of man.'"[183]

Even conditions dangerous to life were framed with hopeful language. In 1933, Paul D. White wrote about hope for those who experience coronary thrombosis based on a case study:

> Points of especial [sic] interest and importance in this case are (1) the patient's longevity, for he survived the acute coronary thrombosis by seventeen and a half years and lived to the ripe old age of 80 years in spite of it; (2) that when the patient finally did die, his death was not due to heart disease (but to cerebral hemorrhage). . . . Here is a case which may serve . . . to put hope into the breasts of the many victims of coronary thrombosis who, having recovered from their acute attacks, still live in dread, waiting for the sword of Damocles to fall in the shape of a second and fatal attack.[184]

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[182] John E. Weeks, "Cause of Cataract and Nonoperative Treatment of Incipient Senile Cataract," *Journal of the American Medical Association* 94, no. 6 (February 8, 1930): 407.

[183] "Foreign Letters," *Journal of the American Medical Association* 105, no. 15 (October 12, 1935): 1201.

[184] Paul D. White, "Longevity after Coronary Thrombosis," *Journal of the American Medical Association* 100, no. 4 (January 28, 1933): 235.

Another author also explicitly took a sanguine tone in his discussion of thrombosis. Arthur M. Master recognized the "grave significance" of heart disease and the increase of its prevalence because of longer living and reduced mortality from infectious disease. He is not chastened: "I shall paint an optimistic picture, in spite of the fact that the most serious of the heart muscle disease, namely, acute coronary artery occlusion, is my subject."[185]

The pages of the *Journal of the American Medical Association* reveal evidence of this desire for precision and the hope of what it can achieve in the increased number of articles and letters concerned with describing health and sickness in old age. An article in 1922 invokes the metaphor of battle, explicitly positioning old age as an enemy: "Newer methods of investigation permit the problem of senescence to be attacked under the controlled conditions of experiment, and many principles of importance have been discovered." These principles included the ways that the living body behaves with respect to age "exactly like a simply colloidal jelly," the observation that younger animals have better results with tissue cultivation than older animals, and that the life of the fruit fly is connected to the production of destruction of some unknown substance.[186] If this unknown substance could be discovered, does this author believe that it could affect the "problem" of senescence that he invokes earlier in the article? While I cannot knows

[185] Arthur M. Master, "Coronary Artery Thrombosis with Treatment by Prolonged Rest in Bed and Low Calorie Diet; Improved Prognosis," *Journal of the American Medical Association* 105, no. 5 (August 3, 1935): 337.

[186] "The Experimental Investigation of Senescence," *Journal of the American Medical Association* 78, no. 1 (January 7, 1922): 36.

formulation is another example of investigators setting their sights and methods upon the body in decline.

This spirit continued as scientists and physicians sought to locate sources of biological, "normal," and pathological aging. During this decade, large interdisciplinary research networks had not yet become the norm; research labs worked primarily in isolation from one another.[187] The interest in aging and old bodies was not limited to the United States; the *Journal of the American Medical Association* offered examples that many physicians abroad were also interested in the study of aging. In 1921, the Belgium Society of Neurology and Psychology celebrated its twenty-fifth anniversary with a presentation on the "Psychologic and Anatomic Study of Senility."[188] Two main points about the presentation were published in the journal: Senile decadence is pathological, and that with age comes a psychologic state of "egoism combined with euphoria and general indifference." [189] From Berlin came a letter describing statistical information garnered from Quakers living abroad. Senility is listed as the fourth main cause of death, with an interesting aside worrying the notion of aging as disease that reads, "so far as old age may be regarded as a distinct disease."[190] An announcement was published in 1926 that Prague had opened a clinic specifically dedicated to studying old age and its correlated diseases. The announcement explains that "the clinic is the outgrowth of a feeling that there is a special pathology of old age as there is of childhood. . . . Two

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[187] See Achenbaum, *Crossing Frontiers,* chapter 2, for further discussion.

[188] "Belgium," *Journal of the American Medical Association* 77, no. 4 (July 23, 1921): 300–301.

[189] Ibid., 300.

[190] "Foreign Letters: From Berlin: Deaths During WWI in Prussia," *Journal of the American Medical Association* 78, no. 10 (March 11, 1922): 748.

groups of diseases of old age must be studied at the clinic: diseases that are specific for old age and ordinary diseases that present a different clinical picture when occurring in old age." [191] In 1931, an explicit though "non-official" call came from Italy. The correspondent, who wrote a note from the Internal Medicine Society of Italy's thirty-sixth meeting, included the following: "In a non-official discussion, 'Weinberger showed the need of study on diseases of old age, suggesting that they should constitute a medical specialty to be termed gerontology.'" [192]

Through the middle and late 1920s, physicians and researchers continued to concern themselves with effecting the fullest potential of the lifespan, as well as postulating on the eventual conquering of the limits of life. Descriptions of health and healthiness were often bound to the hope of prolongevity. H. H. Drysdale took this tack while making an argument in favor of gerontologic research in 1924: "The achievements of preventative medicine during recent years have been truly epochal. The child of today finds itself surrounded by every conceivable heath safeguard. . . . All this is commendable and highly desirable, but it should not end there. Does not the other extreme of life require the same special care and attention if the human machine is to continue in a state of efficiency for the greatest number of years? The preservation of health and the prolongation of life is therefore a highly important consideration, and this constitutes the subject of my thesis."[193]

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[191] "Foreign Letters: Prague: Clinic for Study of Diseases of Old Age," *Journal of the American Medical Association* 86, no. 22 (May 29, 1926): 1711.

[192] "Foreign Letters, Italy" in *Journal of the American Medical Association* 96, no. 15 (April 11, 1931): 370-371.

[193] H. H. Drysdale, "Neglected Factors in the Prevention of Apoplexy," *Journal of the American Medical Association* 83, no. 2 (July 12, 1924): 104.

Drysdale weighs the inevitability of old age with the promise of medical treatment, implying that medicine can help to solve the conditions that contribute to elder suffering. He writes, "Finally, I may add that none can escape growing old provided they live long enough, but the condition of presenility, when detected early, can be deferred by directing the activities of the patient along wholesome and healthier channels. The service of lifting mankind to higher planes of living, and reducing to a minimum the sordid misery and needless infirmities arising from presenility, is a phase of preventative medicine that concerns the neurologist. Each and every one of us should be prepared to shoulder the responsibility."[194]

Three years later, in 1927, an editorial weighs the prospect of maximizing a life, postponing death, and eventuating prolongevity: "Indications from modern biologic investigations might lead to the conclusion that death is neither inevitable nor fundamentally necessary. The 'immortality of protoplasm' is at once suggested by the modern study of tissue cultures. . . . On the other hand, there are plenty of indications of Conrad's reminder of the 'father death that never forgets in the press of work the most insignificant of its children.' Pearl has argued that the potential duration of life is definite and unchangeable; it is a function of bodily organization. . . . Rarely, however, is this full potential span of life realized."[195] The hope of pushing the limits of death back is horizonal, but each time the horizon is invoked, the underlying eschatological narrative is fortified.

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[194] Ibid., 107.

[195] "The Changing Records of Mortality," *Journal of the American Medical Association* 89, no. 2 (July 9, 1927) : 1117.

The descriptive goals of the physiologists, those of uncovering the mysteries of age, dovetailed with the goals of the more explicit prolongevitists in the 1920s. Emerging research in endocrinology, combined with hopes for rejuvenation inspired in the late nineteenthcentury by Brown-Séquard, Malinconico, and other prolongevitists, set a research agenda that held great promise for those who hoped to cure the "problem" of aging. By the 1920s, Brown-Séquard's and Metchnikoff's ideas had been debunked. The prodigious claims of mastering the natural universe were becoming more subdued, yet the horizon remained fixed. The hope of knowing old age was and remains connected to the hope of controlling it, and controlling the body means that suffering too can be controlled in similar ways.

To early twentieth-century physicians, perhaps the most promising location for increasing human life was in the endocrine system. Vigorous discussions filled the pages of the *Journal of the American Medical Association* throughout the 1920s and 1930s and reflect changes in the broad discussions about faith in the ability to conquer death. For example, a foreign correspondence published in 1921 discusses endosecretory sources of old age.[196] Two issues later, Harvey Cushing surveyed the immense new literature on the pituitary gland. In the article, Cushing identifies and troubles the extreme hopes of some scientists. Calling Brown-Séquard the "Ponce de Leon of our predecessors," he skewers those who succumb too explicitly to the promise of endocrine manipulation. He worries that "a good many of us . . . have completely lost our bearings in the therapeutic haze eagerly fostered by many pharmaceutical establishments" and are shouting "Glandward,

[196] "Berlin," *Journal of the American Medical Association* 76, no. 23 (June 4, 1921): 1589-1590.

Ho!" [197] Instead, Cushing cautions patience, perserverence, and humility in the face of "abysmal ignorance" in the "fog-bound and poorly charted seas of endocrinology.[198]

That same year, Dr. Hoskins presented another careful analysis of the current research agendas in endocrinology.[199] He recognized the wide spectrum of claims being made about hormones and their uses and functions. Worrying that both the ultra-conservative stance (which deemed the field of endocrinology "absurd") and the ultra-hopeful approach (which touted too many triumphs) were detrimental to the field, Hoskins begins his essay with a warning that "reports of cures are convincing only when accompanied by adequate evidence that suggestion and other accessory therapeutic measures, as well as mere coincidence, have been ruled out as the determining factors."[200]

With that caveat in place, Hoskins discusses some of the promising research in the burgeoning field, including discussion of the thyroid's possible effect on aging:

> It has been claimed with no little plausibility that even slowing down of cell metabolism incident to old age can be more or less prevented by the judicious use of thyroid. Interesting, in this connection, is the claim that under suitable conditions of dosage the anabolic as well as the catabolic processes, can be augmented by thyroid medication. Incidentally, the whole problem of the relations of the thyroid to senescence demands more extensive and more careful study. Thewliss states that the anatomic changes of old age do not, in themselves, account for the functional deterioration. The implication of this is that the tissues are capable of greater activity than they display."[201]

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[197] Harvey Cushing, "Disorders of the Pituitary Gland: Retrospective and Prophetic," *Journal of the American Medical Association* 76, no. 25 (June 18, 1921): 1722.

[198] Ibid., 1721.

[199] R. B. Hoskins, "Some Current Trends in Endocrinology," *Journal of the American Medical Association* 77, no. 19 (November 5, 1921): 1459–1462.

[200] Ibid., 1459.

[201] Ibid., 1460-1461.

Hoskins's earnest tone is more subdued than that of writers of even twenty years prior. His hope is tempered by the complexity of the field, but it nevertheless is present. He ends the essay by saying, "The end of the whole matter is this: Endocrinology is one of the most difficult fields of biology. . . . There is no easy road in endocrinology, either to discovery or to knowledge gleaned. On the other hand, it would be unfortunate to assume that none but supermen can hope to bring forth significant results. There are many problems demanding solution, which require, not genius, but merely accuracy and patients together with recognition of the ordinary criteria of evidence in any field."[202] Hoskins buffers the optimism of previous years with modesty, but he is not willing to abandon the hope and promise of research.

Months later, another author tries to unmask the problems with two popular endocrinological methods of partial rejuvenation. Acknowledging the hope and quest for youth, the author addresses both the limitations of the promises, and the hope that drives the work: "Neither offers, for example, to grow natural teeth to replace artificial dentures, or to garnish a bald pate with a luxuriant thatch. Yet, if a method will renew sexual vigor—and this is the alluring promise—full many a Faust will eagerly barter his worldly goods for drafts from the fountain."[203] The first method involves transplanting testicular substances from "young men, monkeys, goats or whatever the market affords."[204] The author criticizes this method and its "fundamental error" in the

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[202] Ibid., 1461.

[203] "Rejuvenation by Testicular Transplantation and Occlusion of the Seminal Ducts," *Journal of the American Medical Association* 79, no. 2 (July 8, 1922): 137.

[204] Ibid.

"assumption that vigor in general and erectile power in particular are measured solely by some testicular internal secretion."[205] Another assumption in this method is that transplanted tissue functions in the new environment. The author cites evidence of a French physician, Tuffier, who implanted ovarian tissue into postmenopausal women 230 times with hardly any menses resumption in the women. He also says that "no work on testis transplantation so convincing as Tuffier's ovarian transplants has come to our attention."[206]

The second method critiqued is the Steinach Method, which involves vasectomy as a pathway for rejuvenation. This method, according to the author, also succumbs to the error of "measuring vitality in terms of testicular secretion."[207] The Steinach method of rejuvenation is even faultier. The author criticizes the method, saying that "the flaws in this argument are glaring and numerous and overwhelming critical evidence [is] that occlusion of the seminal ducts does not rejuvenate an old man." Rather, the author chalks up reports of rejuvenation to the convincing of a person ahead of time leading to a sort of placebo effect.

The case was pleaded again in 1923:

> The far-reaching possibilities of this biologic revolution now thrust on us bewilder the imagination. . . . Obviously there need be no more senility, nor more death from old age. All middle-aged and elderly men are to be restored to their youthful vigor, peaceably if they will, forcibly, by law if they must. . . . In short, everybody will be happy except young men; they will be handicapped in the struggle for the world's goods, because they will have no more physical, and less mental equipment than their rejuvenated fathers and grandfathers. And, horrible

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[205] Ibid., 138.

[206] Ibid.

[207] Ibid.

> thought, the old men might be mean enough, through repeated rejuvenation, to maintain this lead indefinitely. [208]

Concluding his attack, the author abandons the moral argument against prolongevity and leaves his reader with a criticisms of the scientific merit of the work: "There is, then, in support of this so-called rejuvenation method, only a mass of poorly supported, uncontrolled clinical evidence and some laboratory evidence not bearing directly on the point concerned."[209]

It is important here to remember that an eschatology is manifested by both promise and fulfillment, so the failure of these rejuvenation techniques challenged the claims of the eschatological narrative and, by extension, challenged scientific medicine's claim of controlling the process of aging. All research is fundamentally an effort in hope, supported by rigorous thought and careful planning. The failure of the promise of manipulating the endocrine system to enact longevity resulted in its never being fully embraced by scientists.

In spite of the critics, some ambitious physician-scientists remained motivated by the eschatological narrative and continued research into methods of prolongevity. The strong condemnation of rejuvenation methods in 1922 did not stop the journal from publishing accounts of respected physicians attempting to restore youth in patients. Their pursuits, and the responses to the efforts, illustrate the necessity for modifying and

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[208] "The Facts about Rejuvenation," *Journal of the American Medical Association* 81, no. 6 (August 11, 1923): 479. Despite the criticisms, the hope located within the endocrine system continued to inspire researchers well into the decade. The president of the Paris Academy of Medicine gave a presentation on the physiological function of the thyroid gland in 1928 during Madrid's "Medical Week." The president mused on the phenomenon of old age and the possibility of messenger and receptor systems that could be connected to the aging process. He said, "some animals, as fishes and snakes, grow indefinitely until some accident puts an end to their lives. Is it possible that in higher animals the receptive substance disappears after a certain period, thus preventing further growth?" in "Madrid," *Journal of the American Medical Association* 90, no. 6 (February 11, 1928): 477.

[209] "The Facts about Rejuvenation," 479.

revising the medical eschatology. Concurrent with the more radical efforts at extending the lifespan, physicians and researchers worked to make old age free of disability and decline. The telos of the eschatological narrative was modified, but its claim of solving the problem of suffering by focusing upon the body continued. In the next chapter I will discuss this iteration of the narrative and its relationship to the maturation of gerontology and geriatrics.

CHAPTER 4: MATURATION OF THE ESCHATOLOGICAL NARRATIVE

THE SECOND SHIFT: CONTROL OF THE AGING BODY PROMISES A DEATH FREE OF SUFFERING

In the 1920s, the eschatological narrative underwent modifications as physicians and researchers had more options of study made available to them. Real progress was made through the development of medical specializations, public health works, and advancement in research discoveries. These developments actualized the eschatological narrative's inherent promises and helped sustain the faith that the hopes and expectations were valid. Indeed, through the careful use of the intellect, humans were saving other humans from early death and various traumas.

With such momentum, elder bodies became sites for the hopeful expectation claimed within the eschatological story and those who operated with its promises. The victories, however, spurred on the desire for more technological advancements. The vision of the end times became less explicit even as hopes became increasingly overreaching and distorted. The desire for ultimate, godlike power over the body is unattainable, but the limits and boundaries of humanity continue to be pressed ever further. Control of life and death was, and continued to b,e undertaken in the quasi-religious faith that suffering could be eliminated. Prolongevists pushed the edges of human life as they attempted to extend it. During this time, geriatrics and gerontology professionalized, and though their goals were much more modest than the prolongevists', they still adhered to the eschatological narrative's promise that better health lay just beyond reach and that it could be attained through description, management, and control of the elder body.

Researchers in the third decade of the twentieth century worked to describe and control the processes of aging. Despite these strides—or, perhaps, in spite of them—some physicians and researchers recognized more explicitly the impossibility of conquering death. The tangible benefits of medical progress butted up against the relatively fixed length of the human life span, forcing physicians and researchers to consider the limitations of their claims.

The two forms of the eschatological narrative have come to work alongside one another. An example will demonstrate how the hope of prolongevity became transfigured into a different kind of iteration of the eschatological narrative. Posted in the foreign correspondence section of an October 1923 issue of the *Journal of the American Medical Association* came a report of Dr. L. Cardenal's address, which was given in order to be admitted into Spain's Royal Academy of Medicine.[210] Dr. Cardenal, a professor of surgery in Madrid, presented his study of rejuvenation in fifty-eight men. The study, though ethically troubling, was indicative of the hope encapsulated by 1920s prolongevitists. The subjects of the study, ranging in age from less than forty years (termed "prematurely senescent") to more than sixty years, had their vas deferens ligated or their small efferent ducts ligated on one or both sides. Seven of the subjects were lost to observation, and no results were noted for the men whose vas deferens were ligated. Of the thirty-eight subjects presented, fourteen cases were described as "total failures," although the commentary gave no other description of what failure entailed. Twenty-four men were described as having shown marked improvement through increased weight and changes in skin and hair. "Practically all" of the patients showed improvements in

[210] "Madrid," *Journal of the American Medical Association* 81, no. 14 (October 6, 1923): 1221, 1222.

mental function, with the notable example given of a man older than seventy who was learning to read.

A response to Cardenal's presentation was given by Dr. Gregorio Marañon, the youngest member of the Royal Academy of Medicine.[211] Dr. Marañon was only thirty-five when he responded to Cardenal but was already a highly respected physician and scientist. Well-regarded within Spain's history of medicine, he is called a pioneer of the study of endocrinology in Spain. Marañon's response is notable in the way that he simultaneously invokes and disavows eschatological language. Marañon uses the metaphor of the body as machine and old age as the time when "the main spring finally gives out." He argues that attempting to force the hands of the clock to "stay their onward march" is "merely self-deception" and that even if rejuvenation were possible that it would not be worthwhile.[212] Marañon does not want to offer false hope regarding immortality and worries that rejuvenating hormones would harm the body over time.[213]

Instead of offering the hope of prolonged life, Marañon offers the hope of an old age free from suffering. The role of the physician, according to Marañon, should not be to extend life indefinitely, but rather to "decrease the discomforts of old age, so that the man will not be plunged abruptly into the ocean of death as by a cataract, but will travel gently toward it, borne by a quiet stream."[214] Despite this nod toward the reality of death, Marañon still calls forth the ideas of mastery when he goes on to say:

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[211] See Arturo Zarate, "Gregorio Marañón, a Pioneer of Endocrinology, 50 Years after His Death," *Gaceta médica de México* 147, no. 2 (April 2011): 176–179.

[212] "Madrid," 1221.

[213] Ibid.

[214] Ibid.

> Let us conquer old age, not fear or shirk it; let us try to make old age more pleasant for others. Let us remember that old hearts retain their sensitiveness; that the wrong views of the old man were the truths of his youth, and that what we now considered to be truth may tomorrow be replaced. Let us find in their failings, not a source of irritation, but a hint to men our own defects. If to this is added perhaps a little endocrine surgery, we shall succeed, not in the futile efforts to banish old age, but in making it painless.[215]

In these words, the eschatology is reckoned with, but not given up entirely. Even if old age could not be currently obliterated, its unpleasant aspects could be neutralized to such an extent that suffering is ameliorated.

Cardenal and Marañon demonstrate the subtle shift in how physicians and scientists talked about the goals and claims of the eschatological narrative. The audacity of claiming that senescence could be eliminated altogether opened up more veiled, but still present, ways of articulating hope and promise. If not conquered entirely, then aging could be managed scientifically in increasingly sophisticated and precise ways. These writers did not speak with Sir William Osler's sanguine fervor, but they continued to work toward achieving progress nevertheless.

Various methods were presented from the 1920s through the 1930s suggesting that health and youth could be lengthened through control of the body and faith in the medical profession. One writer, extolling the virtues of calcium, wrote, "An increase in the proportion of milk . . . confers improved health and vigor throughout adult life, actually postponing old age in the same individuals in which it has induced better growth and earlier maturity."[216] In 1930, a Parisian professor named Delbet argued that

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[215] Ibid.

[216] "Queries and Minor Notes," *Journal of the American Medical Association* 92, no. 12 (March 23, 1929): 1008.

magnesisum was “a worth-while method of retarding the onset of old age,” although it must be noted that a few months later, the foreign office from Paris sent another note recounting the censuring of an unnamed professor, who had published on the relationship between magnesium and the onset of old age, for allowing his name to be used to promote a magnesium chloride tablet.[217]

Other researchers experimented on themselves in the hope of demonstrating positive effects of staving off the ravages of aging. The “Current Medical Literature” in the *Journal of the American Medical Association* during 1925 reports a scientist named Zoth who administered testicular extracts to himself. He argued that the “only rational way to testing the efficiency of any method endeavoring to prevent senility is to start using it before old age sets in.”[218] To that end, this scientist began administering testicular extracts to himself every summer beginning at the age of thirty, and published a note in the journal inviting others to do the same. At over sixty years old and with more than thirty summers of this self-experimentation, Zoth offered anecdotal evidence of "muscular efficiency" and "easy recovery from various infections," though he experienced no positive benefit sexually.[219]

The legacies of this shift within the eschatological narrative from the conquering of death to the conquering of disability continue to have profound implications for the positioning of elders in the realm of medicine today. In the following years an increasing body of research gave hope to the ideal that morbidity and chronic diseases could be

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[217] “Paris,” *Journal of the American Medical Association* 94, no. 16 (April 19, 1930): 1250,1251.

[218] “Current Medical Literature,” *Journal of the American Medical Association* 85, no. 18 (October 31, 1925): 1438.

[219] Ibid..

managed in such a way that the problems of old age could be minimized so that superior health could be sustained almost indefinitely. This body of thought ignores the deep kaleidoscopic nature of elder suffering by attaching inflated hope upon finding better ways to slow deterioration so that elder bodies can remain utterly healthy until they "pass away" in an unencumbered, peaceful death. The gravity, terror, and challenge of addressing suffering are ignored within this modified incarnation of the narrative.

By 1929, the pathology professor Dr. Aldred Scott Warthin, of the University of Michigan, had entered into the discussion about the aging process, addressing misplaced hope for rejuvenation and prolongevity. In 1928, Warthin had given a keynote lecture to the New York Academy of Science on "the pathology of the aging process."[220] The *Journal of the American Medical Association* picked up on Warthin's work and discussed his contribution to the study of senescence in an editorial.[221] Warthin dismisses the hope for rejuvenation as "useless," but "perhaps one of the impelling motives that animate the dying man to the end of his existence."[222] He scorns the prolongevity efforts of Brown-Séquard, Metchnikoff, and others, particularly those who studied hormones as the means for rejuvenation, saying that "it is a sad commentary upon the mentality and character of the senile human male that he should seek an auto-eroticization of his failing function." He goes on, pointedly, to criticize these efforts as "a myth of ancient lineage disguised in quasi-scientific garments."[223]

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[220] Aldred Scott Warthin, "The Pathology of the Aging Process," *Bulletin of the New York Academy of Medicine* 4, no. 2 (October 1928): 1006-1046.

[221] "Old Age," *Journal of the American Medical Association* 93, no. 1 (July 6, 1929): 35–36.

[222] Ibid., 35.

[223] Ibid., 36.

Given his stance toward mortality, one might believe that Warthin would be positioned well to revise the eschatological narrative and help minimize its potential for increasing human suffering. Indeed, Warthin believes that many of the changes brought about by senescence are a matter of physiology, not pathology. As the editor summarizes: "Warthin's study of the phenomena of old age and death is really a study of the cycle of human life."[224] His book divides human life into three major periods: evolution, maturity, and involution, "which he would put in the individual who arrives at the end of intrinsic senile death at approximately 90. His thesis is that this is the natural cycle of human life, an intrinsic quality of its vitality and that it is beyond man's power to modify."[225]

Speaking, according to the reviewer, as both a pathologist and philosopher, Warthin forecasts sociobiologists like Edward O. Wilson, Stephen Jay Gould, and Richard Dawkins, by locating the purpose of life in reproduction. Senescence is not only a result of physiologic wear and tear, but also, more importantly, a purposeful mechanism "for getting rid of the organism, itself, as a whole. This can mean but one thing: the individual human machine has fulfilled its function, and now, useless, stands in the way of the progressive evolution of the species."[226]

The old person's function in this conceptualization of life has little, if any, usefulness; and Warthin and the reviewer offer meager consolations to the elder. The editor writes that Warthin's book

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[224] Ibid., 35.

[225] Ibid.

[226] Ibid.

> has the cheerfulness and optimism that comes from a courageous and honest facing of facts. But if age is inevitable, what shall be done about it? Meet it, of course, with courage and common sense, as something in the day's work, not pleasant wholly, but as the final turn of the screw, to be endured with that fortitude, that in enduring acquires a quality of satisfaction. Moreover, the possibilities of normal old age are great; it is the period of ripeness of experiences and observation, of the contemplation and philosophical evaluation of the world around us, of quiet brooding and the creative possibilities engendered by such. . . . Since the mental functions are preserved longer than any other function in senescence, happy is that old man who comes into his old age with the capacity for intellectual pleasures fully developed, not in one line alone, but in many, in literature, art, music and science.[227]

Warthin's eschatological vision, rooted in the promise of cure and management, is not revealed for the elder who has outlasted his reproductive usefulness. Hope for the future creeps into Warthin's work, but the elder is denied access to it. Warthin believes that the human race is marching forward toward some telos marked by destiny and biological drive: "The continuation of the species for some future destiny, perhaps state of perfection, which we cannot glimpse, and that in this purpose the individual machine is but a temporary, albeit necessary, incident in the life of a species, and the latter in its turn is also only an incident in the collective life through the eons."[228] Warthin, with the good intentions of limiting false hope for elders, still manages to push them to the side as weak casualties of the grander narrative of progress.

The "Current Medical Literature" of 1928, discussing Warthin's presentation to the New York Academy of Medicine, reveals the painful prospect for elders as envisioned by Warthin:

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[227] Ibid., 36.

[228] Ibid.

> What modern medicine has accomplished along the lines of hygiene and the prevention of diseases has been only to increase the number of human individuals, both the fit and the unfit—unfortunately, too many of the latter kind—who come to maturity and to the period of senescence. More individuals will achieve their biologic life limit; and this means ultimately a much greater increase in the number of senile, more or less useless human beings of the eighties and nineties.[229]

The fear of the useless elderly encouraged some physicians to call for better social support of the aged. An editorial from 1928 built on Warthin's definition of senescence as something immutable. Drawing upon Morris Fishbein's commentary, the writer discusses the "mixed blessing" of increased years of life and the consequences of increasing the years of lives:

> Our state makes no provision for the aged. Our octogenarians and nonagenarians, without means of subsistence and for the provision of nursing care, are pitiable objects. The zealous advocates for life extension have not paused to consider what the effects of an average longevity rate of 65 years would mean to society at large. In every community, as emphasized also by Warthin, there would be a greatly increased group of dependents, nonproductive, useless, more or less uncomfortable, and unhappy burdens to everyone as well as to themselves. Obviously, society must develop plans for the care of the aged if it is to keep pace with what scientific medicine is accomplishing in the prolongation of life.[230]

The *Journal of the American Medical Association* also published a small reprint from the *Bulletin of the Johns Hopkins Hospital* that examined cosequences of the longevity efforts. Physician W. T. Longcope writes:

> As I grow older, I have less and less sympathy in the conscientious efforts merely to extend life in old age. The curtailment of activities, the tender nursing, the humane and assiduous attention of doctors are apt, too frequently, to carry the aged tottering to the danger point and leave them helpless doddering wrecks of

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[229] "Current Medical Literature," *Journal of the American Medical Association* 91, no. 25 (December 22, 1928): 2026.

[230] "The General Practitioner, Clinical Organization, and Physical Examinations," *Journal of the American Medical Association* 91, no. 26 (December 29, 1928): 2067- 2068.

> humanity. Having arrived at this stage, it seems beyond their power, or desire, to let go the one thing they possess, that shred of life that ties them uselessly to earth. . . . It is the duty of the doctor to preserve, not only health and life, but joy of living.[231]

A 1935 editorial in the journal suggests that little beyond the platitudes of the nineteenth century could be offered by medicine to the elderly.[232] The editor ruefully notes that advances in hygiene and sanitation have increased general life expectancy, but primarily for children. "Little has been accomplished in the health and mortality in older persons," he writes.[233] The editor places a particular cause of mortality of the elderly in degenerative diseases, but recognizes that a number of factors contribute to health, including "heredity, diet, habits of work and thought, pleasures, climate, economic status, social position, profession or occupation, race, and exposure to infectious diseases."[234] The author then describes in detail some of the biostatistical views on aging noting that while the general trend is that life expectancy is growing, that trend cannot be generalized to individual longevity. After describing some studies that suggested protective characteristics, such as marriage, tall height, and a "quiet life" of rural and temperate living, the editor admits that "longevity is an art as well as a science."[235]

For a pleasant old age, the editor falls back on the same advice given during the nineteenth century. Old people, says the author, should "cultivate equanimity,

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[231] W. T. Longcope, "The Joy of Living," *Journal of the American Medical Association* 98, no. 13 (March 26, 1932): 1081.

[232] "Prolongation of Human Life," *Journal of the American Medical Association* 105, no. 3 (July 20, 1935): 202–204.

[233] Ibid, 202.

[234] Ibid.

[235] Ibid, 203.

contentment and optimism" and "avoid anger, envy and jealousy."[236] To this advice he adds the importance of following a moderate diet. He soothes his readers with examples of elders who remained productive late in life, such as Michaelangelo and Cornaro.

Being able to offer only this slim solace, the editor turns his eye back toward the horizon: "Geriatrics is a neglected field of medicine. . . . Many biochemical mysteries are involved [with senescence] . . . which challenge the curiosity and spirit of the scientific investigator."[237] The end of the editorial invokes the hope of Metchnikoff, saying that when science is appreciated more and when hygiene continues to advance, "human life will become much longer and the part of old people will become much more important than it is today." [238] Not being able to offer the longevity he would like, the editor directs the reader toward the future.

The explicit verbiage of scientists who hoped to propel humanity to the Elysian field of immortality continued to fall out of fashion as science became more cooperative and complex, but the previous decades' conversations had already begun to exert influence. Increasingly part of medicine's social imaginary, the eschatological narrative converged with a number of other factors to embed and solidify the disordered expectations of a suffering-free existence for elders. My focus is on three of these factors: the expansion of the scientific enterprise into a collaborative and multilevel effort, the maturation of gerontology and geriatrics as specialized ways of engaging the scientific enterprise, and the triumph of the therapeutic model of healing.

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[236] Ibid.

[237] Ibid.

[238] Ibid., 204.

First, a whirlwind of scientific expansion occurred in the decade preceding World War II and the two decades that followed it, with the war being a moment of tremendous reorganization. Research transitioned from relatively small, often directly therapeutic projects involving no more than a few like-minded scientists to sophisticated, collaborative, multi- and interdisciplinary efforts. The logistics surrounding research, including those which focused on the aging body, became more cooperative and complex. Through this multi- and interdisciplinary work, harder and more perplexing challenges could be described and analyzed.

The Rockefeller Foundation, established in 1913, made strong financial commitments to medical education and health care, citing disease as "the supreme ill in human life."[239] In 1923, one of the Rockefeller Foundation's original trustees and champion of public health, Wickliffe Rose, explained the global stakes of scientific progress: "This is an age of science. . . . All important fields of activity, from the breeding of bees to the administration of an empire, call for an understanding of the spirit and technique of science. . . . Promotion of the development of science in a country is germinal; it affects the entire system of education and carries with it the remaking of a civilization."[240] E. Richard Brown argues that "capitalists and corporate managers . . . embraced scientific medicine as an ideological weapon in their struggle to formulate a new culture appropriate to and supportive of industrial capitalism."[241]

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[239] Rockefeller Foundation, "Who We Are," http://www.rockefellerfoundation.org/about-us/our-history/1913-1919. Accessed February 15, 2015.

[240] Robert E. Kohler, *Partners in Science* (Chicago, IL: University of Chicago Press, 1991),137-138.

[241] E. Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley, CA: University of California Press, 1979), 10.

In July 1941, Franklin Roosevelt created the Office of Scientific Research and Development (OSRD), which supervised committee work on both national defense and medical research.[242] The office, under the direction of Dr. Vannevar Bush, presented unparalleled funding opportunities to scientists and resulted in tremendous research development. By 1945, when Bush published the OSRD-commissioned report, *Science—The Endless Frontier,* he could rightly boast the great boons of scientific development supported by the OSRD: the development and production of penicillin ("which saved countless lives" and prevented "incalculable suffering"), radar, technology that delivers paychecks, manufacturing, and advancements in agriculture.[243] Bush argues that "advances in science will also bring higher standards of living, will lead to the prevention or cure of diseases, will promote conservation of our limited national resources, and will assure means of defense against aggression."[244] Bush's document is part of the historical lineage that used monumental scientific achievements to justify the value of the scientific enterprise. With the backing of the United States government, huge sums of money became available to support the incredible advancements.

After the war, the National Institutes of Health (NIH) continued in the OSRD's wake. A federal medical advisory committee postulated that "it is not unlikely that significant progress in the treatment of cardiovascular disease, kidney disease, cancer, and other refractory conditions will be made, perhaps unexpectedly, as a result of

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[242] See Rothman, 31, and Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York, NY: Basic Books, 1982), 338-343.

[243] Vannevar Bush, "Science, The Endless Frontier," http://www.nsf.gov/od/lpa/nsf50/vbush1945.htm, accessed February 15, 2015.

[244] Bush, "Chapter 1: Introduction; Science is Essential," http://www.nsf.gov/od/lpa/nsf50/vbush1945.htm#ch1, accessed February 15, 2015.

fundamental discoveries in fields unrelated to these disease."[245] Within the next two decades, the budget of the NIH would grow to $1.2 billion dollars.[246]

To what end were these important challenges undertaken? The horizonal aspirations of medicine suggest that the end goal of describing a problem is to control or solve it, and although the medical enterprise has become ever more silent about its religious features, it continues to position research and discovery as the ways in which the curiosities of the natural world could be demystified. As the therapies, pharmaceuticals, and technologies cash out their dividends, the assumption that life's mysteries were simply problems that could eventually be solved became self-evident, rather than a belief to be interrogated.

Second, gerontology as a scientific enterprise matured. The care, cure, and medical management of the elderly continued to challenge physicians during this time, and the expansion of the biomedical research complex affected gerontology and its application in geriatrics in important ways. The 1930s were an important decade for gerontology because it was during this time that gerontology became "reconstructed . . . as a collective, scholarly enterprise" that enabled gerontology to emerge as a science.[247] Tycoons like Will Keith Kellogg and John D. Rockefeller, or, in the case of the late Josiah Macy Jr., his daughter, poured their wealth into philanthropic organizations that supported elaborate research in the service of maintaining a thriving capitalist society.[248]

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[245] W. Andrew Achenbaum, *Crossing Frontiers: Gerontology Emerges as a Science* (Cambridge, UK: Cambridge University Press, 1995), 92.

[246] Ibid.

[247] Ibid., 54.

[248] For a further history of the connection among capitalism, medicine, and philanthropy in the early twentieth century, see Brown, *Rockefeller Medicine Men*.

Healthier people could spend more years in the work force, so the philanthropists were eager to foster a medical system that could support this goal.

The minimization of suffering continued to be named as an overarching goal of its efforts. Kate Macy Ladd's Letter of Gift, establishing the philanthropic foundation in the name of her father Josiah Macy Jr., specifically says that the Foundation "should primarily devote its interest to the fundamental aspects of health, of sickness, and of methods for the relief of suffering."[249] Suffering, however, was not defined in a robust way, and the narrowly curative focus upon the research projects of the foundations suggest that the "relief of suffering" was bound to the management of the body's unavoidable aberrations and the attempt to fit the body into margins deemed "normal."

The Macy Foundation addressed problems of aging early on in its history. In 1931, only a year after establishment, the foundation consulted Dr. Edmund Vincent Cowdry, the chair of the Division of Medical Sciences of the National Research Council, who agreed to help the foundation organize a plan of "attack" for the problem of arteriosclerosis, an occurrence considered to be a pathological abnormality of aging. What eventuated from this collaboration was the first conference on aging in 1937, a handbook on arteriosclerosis, and an ongoing relationship with the Macy Foundation that would spur further research culminating in the first American handbook of gerontology, *Problems of Ageing* [sic], published in 1939.[250] Historian W. Andrew Achenbuam argues that this publication was a watershed moment, marking gerontology's entrance

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[249] The Josiah Macy Jr. Foundation, "History," http://macyfoundation.org/about/history, accessed February 15, 2015.

[250] Edgar Allen, *Problems of Ageing: Biological and Medical Aspects,* ed. Edmund Cowdry (Philadelphia, PA: Williams & Wilkins, 1939).

into the “modern era." The book brought together twenty-five authors from many disciplinary backgrounds who were already established researchers with the hard-won respect of their peers. The handbook’s focus was varied, demonstrating the wide ways that aging can be studied, as well as the difficulty in attempting to unravel the mysteries of human aging.

The authors who contributed to *Problems of Ageing* sought to address the tension between pathological and “normal” aging and the relationship between the two as they contributed to the “problem” of old age. They continued to professionalize the study of aging through the founding of the Gerontological Society of America in 1945. The stated purposes of the society included, among the more strictly biologically focused, “mental hygiene and the art of medicine.”[251] The motto of the society, “Adding life to years, not just years to life,” slyly acknowledges the futility of the immortality projects of the prolongevitists and suggests that the organization included as its focus the alleviation of suffering.

The 1945 bylaws of the Gerontological Society illustrate the priorities and challenges of creating cohesion out of such widespread interests. The 1945 divisions were named Medical Research, Biological Research, and General Section.[252] Over time, the groups were altered; four divisions currently make up the society: Biological Sciences, Behavioral and Social Sciences, Health Sciences, and Social Research, Policy,

[251] Achenbaum, *Crossing Frontiers*, 125.

[252] Ibid., 132.

and Practice.[253] Currently, professionals identifying as humanists are encouraged to join the behavioral and social sciences division.

The Gerontological Society of America joined the American Geriatrics Society, which had been founded in 1942. The American Geriatrics Society was a clinical group that stressed the importance of preventative and curative treatment of diseases of the elderly. Both groups focused on continuing to describe senescence and improving the quality of life of elders, and both groups sought to include thinkers from a number of disciplines. The disciplinary focus, however, while varied, generally did not include the humanities.

The Gerontological Society of America published its first journal in 1946. The first edition of the textbook *Geriatric Medicine,* by Edward J. Stieglitz, was published in 1943. In 1950, its second edition was reviewed in the *Journal of the American Medical Association*. Questions of professionalization and identity mark the time. "What is geriatrics?" is a question of increasing insistence, according to the book reviewer.[254] The answer to the question lies in the most prominent change from the first edition to the second: the addition of the subtitle, *The Care of the Aging and the Aged.* By adding the subtitle, the reviewer notes Stieglitz's emphasis that medical care include the "care of the man in addition to the treatment of his illness."[255] On the face of it, Steiglitz's goals are more comprehensive than simply managing the body. The textbook includes sections on political and cultural factors of aging and includes the word *care* in the title. But the

[253] The Gerontological Society of America, "Frequently Asked Questions," http://www.geron.org/About%20Us/Frequently%20Asked%20Questions?start=1#membershipsection, accessed January 1, 2014.

[254] "Geriatric Medicine: The Care of the Aging and the Aged," *Journal of the American Medical Association* 142, no. 1 (January 7, 1950): 68- 69.

[255] Ibid., 68.

goals of the book are also to help the physician "diagnose, cure, care, and rehabilitate" in order to assist physicians in "the prevention of illnesses, the retardation of progressive deterioration, prolonged invalidism, and "*parasitic uselessness*" (italics are mine).[256]

The alleviation of suffering becomes part of the scientific agenda and medical practice only insofar as the old person's body is kept as strong as possible, feeling as good as possible, and for as long as possible. Keith G. Meador and Shaun Henson describe this unfortunate effect as one of the "sick narcissisms of a therapeutic culture," and what I argue is the third converging influence in creating disordered expectations of patients and practitioners. They write, "to feel good has become the ultimate desire, and in order to feel good we struggle to avoid whatever we have come to believe will make us feel bad—including signs of aging in ourselves and others and, at a deeper level, sickness and suffering itself."[257]

The inability to confront the limitations of the eschatological narrative's claims is one particularly forceful effect of the therapeutic culture. The concept of the therapeutic culture comes from Philip Rieff and Elisabeth Lasch-Quinn who, in 1966, traced the changing relationships Westerners have had with culture. Rieff and Lasch-Quinn locate Freud's work as a turning point that shifted ways of thinking about the process of meaning making.[258] The cultural impact of Freud's work, according to Rieff and Lasch-Quinn, helped foster in individuals a sense that culture is a fixed entity; the individual

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[256] Ibid.

[257] Keith G. Meador and Shaun Henson,"Growing Old in a Therapeutic Culture" in *Growing Old in Christ*, ed. Stanley Hauerwas, Carol Bailey Stoneking, Keith G. Meador, and David Cloutier (Grand Rapids, MI.: W. B. Eerdmans, 2003), 100.

[258] Philip Rieff and Elisabeth Lasch-Quinn, *The Triumph of the Therapeutic: Uses of Faith after Freud* (Wilmington, DE.: ISI Books, 2006).

does not act upon culture, but rather mediates between culture and personal instinct. Inner peace comes then not from an outside source, but from the self, analyzing it and making it "serviceable to the outer."[259] After Freud, a new responsibility was imposed upon the Western self to become an expert analyst. Instead of looking to religion, philosophy, or literature to cure a soul's sadnesses, one must turn inward, with a pragmatic and emotionally neutral attitude, to discover one's own existential problems.[260]

For Rieff and Lasch-Quinn, the self has made a shift towards action. The need for action goes hand in hand with the rise of the analytic attitude. Once the individual analyzes the self, it is left to treat itself: "With no place to go for lessons in the conduct of contemporary life, every man must learn, as Freud teaches, to make himself at home in his own grim and gay little Vienna."[261] The self must struggle to find within itself a "tolerance of ambiguities," so that it can find some balance with the conflicting demands found in the confusing and confused modern era.[262]

The self is thus trying to make its way amidst failed ideals and confused missions. Each is on its own, searching for meaning.[263] Searching for egoistic quick fixes to try to repair what has been lost in an increasingly complex Western society, the self is faced

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[259] Ibid., 32.

[260] Rieff and Lasch-Quinn believe that as Western culture has reorganized itself, understandings about the self have also changed: "As cultures change, so do the modal types of personality that are their bearers." Rieff and Lasch-Quinn identify four main ideals of the self: the political ideal embodied in the ancient citizen of the polis, the economic man identified by the industrial worker of the Enlightenment, the religious man who looks to an outside source and grounds himself in faith, and the therapeutic self that arose after Freud, as they relate to the evolution of Western culture. The myths coexist as ideals within society. Each ideal has failed to be enough to "cure" our ever-changing culture from the difficulties and suffering of life. Rieff and Lasch-Quinn, 2.

[261] Ibid, 59.

[262] Ibid., 57.

[263] Ibid., 61.

with an astounding freedom that it never had before. Rieff and Lasch-Quinn see the questing, selfish, confused character that has emerged as the therapeutic self. The *therapeutic self* is "the type of character emerging in contemporary culture—men who acknowledge no structure of belief or loyalty save the realization of their own well-being through the 'healing' of the wounds made by civilization."[264]

The eschatological narrative, borne out of the optimism and promise of the late nineteenth and early twentieth centuries, gave physicians and researchers a story by which they could legitimate their efforts. The narrative gave those engaged in the medical enterprise a method of sustaining hope alongside the analytic attitude and the development of the therapeutic self. Despite the continued telos of death or maybe, more correctly, in spite of death's reality, the eschatological narrative continued to offer scientists and health-care practitioners a story with which they could comfort themselves. Even if they could not offer succor in the present, problems always held within them the hope of being solved in the future. So the story promises.

The three converging factors—the expansion of medical research into a highly organized, well-funded, and multidisciplinary enterprise, the development of gerontology and geriatrics as specialized studies within that enterprise, and the broad cultural triumph of the therapeutic self—made the eschatological narrative particularly difficult to confront or relinquish.

The maturation of gerontology and geriatrics has continued to the present day, and the wide expansion of scientific research in general has resulted in a diversity of research projects among geriatricians and gerontologists. The two arenas are well placed

[264] Ibid.

to confront and rehabilitate the eschatological promises of modern medicine. Their focus, though, has been dominated by methodological inquiries that focus upon naming, describing, and solving biological and social "problems" of aging. With these two areas of inquiry, the elderly person and the aging process are placed squarely into the view of the researcher, from the molecular study of cellular aging to broader social studies of the full life-course.

The priority since the 1940s for investigators of aging has been research on "what they call 'normal,' 'successful,' and 'productive' aging."[265] Most researchers have eschewed the idea that aging is a disease or purely pathological; research centers around ideas of better and worse ways of becoming old. William Satariano, in his textbook *The Epidemiology of Aging*, argues that one of the primary research goals of gerontology is to compress morbidity and postpone mortality.[266] Since the life span seems relatively fixed, the eschatological hope of gerontology rests in the promise that morbidity could be compressed to such an extent that the elder will remain healthy until a peaceful, unbothered death.

The Gerontological Society of America (GSA) now includes more than 5,500 members; the general annual meeting attendance exceeds 3,000 scholars.[267] The GSA publishes established and well-respected peer-reviewed journals that focuses on aging and the biological, medical, psychological, and social sciences. Indeed, with the aging body squarely under the gaze of scholars, scientists, and physicians, the expanse of

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[265] Achenbaum, 2.

[266] William Satariano, *Epidemiology of Aging: An Ecological Approach* (Sudbury, MA.: Jones and Bartlett, 2006).

[267] The Gerontological Society of America, "Fact Sheet," https://www.geron.org/about-us/fact-sheet, accessed February 15, 2015.

research on elders and the processes of aging is staggering. The National Institute of Aging's budget for 2016 is more than one billion dollars.[268]

The two forms of the eschatological narrative—that healthy immortality could be actualized or that the body could be conquered until a natural, comfortable death—overlap; neither precludes the other. The natural limit of death does not prevent researchers from working to achieve the ends of health for as long as possible, with the hope that the body could be controlled up to and including a painless, suffering-free death. The eschatological narrative of health unto death has not prevented the more radical promises of radical health and prolongevity. Scientists are endeavoring to discover methods of organ and tissue regeneration. The eschatological narrative now promises future recovery from all manners of injuries, and the scientists who engage in this research are heavily informed by the claims of the narrative, even if the scientists are unaware of how such a story came to be. Take, for instance, the National Institutes of Health (NIH) fact sheet on regenerative medicine:

> Imagine a world where there is no donor organ shortage, where victims of spinal cord injuries can walk, and where weakened hearts are replaced. This is the long-term promise of regenerative medicine, a rapidly developing field with the potential to transform the treatment of human disease through the development of innovative new therapies that offer a faster, more complete recovery with significantly fewer side effects or risk of complications.[269]

Though not as laden with religious overtones as the pronouncements of the previous century, the NIH fact sheet nevertheless presents, in bulleted form, a great story of the

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[268] National Institute of Aging, "Directors Statement: Fiscal Year 2016 Budget Summary of Changes," http://www.nia.nih.gov/about/budget/2015/fiscal-year-2016-budget/fy-2016-summary-changes, accessed February 15, 2015.

[269] National Institutes of Health, http://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=62, accessed February 15, 2015.

past research, present uses and demand, and the future promise of regenerative medicine. The history is broken neatly into sections of the past, present, and future, with bulleted sentences that present persuasively the hopeful promise held within regenerative medicine. "Yesterday," according to the organization of the history, was marked by successes in increasingly complex multiple organ transplantations; and "today" is seeing the clinical applications of tissue-engineered products. Even with these accomplishments, "today" is imperfect because the aging baby-boomer generation "has caused an increased demand for tissues and organs far exceeding the available donor organs."[270] The promise of the "future" lies in *regenerative medicine*, which is defined as "the process of creating living, functional tissues to repair or replace tissue or organ function lost due to age, disease, damage, or congenital defects."[271] Through regenerative medicine, scientists will be "empowered" to grow and implant tissues and organs even when the body "cannot heal itself."[272]

The force of the promise resonates in the rhetoric of regenerative medicine, as it draws upon the eschatological narrative to ground and legitimate the efforts of its researchers. Within its promise, regenerative medicine asserts that aging is necessarily a bad thing and that humans should intervene to keep the body and its parts young. Suffering, within the story of regenerative medicine, comes only from the decline of the body; keeping the body stocked in fresh parts might eliminate the despair of the human condition.

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[270] Ibid.

[271] Ibid.

[272] Ibid.

In tandem with regenerative medicine stands the most vocal of engineered prolongevity's proponents, Aubrey de Grey. With his long brown beard, de Grey looks akin to a younger Father Time. De Grey's goals, however, are to conquer Father Time through the "defeat" of aging. For more than twenty years, de Grey, a computer scientist by training who experienced an intellectual conversion experience, has spearheaded efforts in the study of longevity and the cure of aging-related diseases. The story of de Grey's conversion reflects aspects of the classic paradigm of religious conversion, with the convert experiencing a dramatic conversion of belief, followed by the intense desire to share the "good news," as it were, of his new world view.

To this end, De Grey helped found and organize the Strategies for Engineered Negligible Senescence (SENS) Foundation, which is a public charity that "develop[s], promote[s] and ensure[s] widespread access to rejuvenation biotechnologies."[273] In keeping with the religiously laden language, the physician Sherwin B. Nuland called de Grey an "indefatigable missionary" for the movement of "biogerontology," which proposes a seven-pronged engineering approach to the mechanisms of the body in order to "defeat aging."[274] His foundation works to extend life, but not for the purposes of immortality in and of itself. De Grey believes that life extension is a by-product of maintaining health by "fighting" the diseases of aging. De Grey reveals his understanding of medicine's goals through his discussion of life extension when he writes, "whilst it is true that the success of rejuvenation biotechnologies will lead to the

[273] AubreyD. N. J. DeGrey, "Strategies for Engineering Negligible Senescence Foundation," http://www.sens.org/sens-foundation, accessed June 2012.

[274] Sherwin B Nuland, *The Art of Aging: A Doctor's Prescription for Well-Being* (New York: Random House, 2007), 193.

extension of healthy life, that's no different to almost the entirety of medicine today: curing disease keeps people healthy, and alive."[275]

The SENS Foundation research advisory board is made up of scientists and engineers studying a gamut of topics, from genomics to stem cell therapies to child neurology to molecular oncology. These men and women are not fly-by-night kooks, but professors at respected medical and academic institutions who work squarely within the parameters of the eschatological narrative's claims and promises. Each research advisor has signed a letter stating that the fruits of the SENS funded research

> may provide many years, even decades, of additional youthful life to countless millions of people. Those extra years will be free of all age-related diseases, as well as the frailty and susceptibility to infections and falls that the elderly also experience. The alleviation of suffering that will result, and the resulting economic benefits of maintained productivity of the populations, are almost incalculable.[276]

The quest for immortality and perpetual health, imagined by the ancients and pursued by explorers, comes to find a scientific home when wed to the form of the eschatological narrative. De Grey's understanding of what medicine does (cure disease) and how old age is understood (a problem to be solved) demonstrates how the narrative can be still be used to imagine an end to death and the specific suffering connected to the process of bodily aging. As previous examples have demonstrated, the narrative form of the eschatological story works by simultaneously invoking the past and present while always looking toward the glorious future. The website for the SENS Foundation utilizes

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[275] Strategies for Engineering Negligible Senescence, "Frequently Asked Questions," http://www.sens.org/sens-foundation, accessed January 2014.

[276] Strategies for Engineering Negligible Senescence, "Research Advisory Board," http://www.sens.org/sens-research/advisory-board, accessed June 2012.

this structure as de Grey writes that the reality of our current limitations should not limit the aspirations of researchers:

> It is informative to think about similar questions which might have been asked at different points over the past century. Can we really do anything about wound infections? After the invention of antibiotics? After the invention of antibiotics the answer was a resounding, "Yes". When will the next outbreak of smallpox occur? After the WHO's program of eradication the answer became, "Never". Cholera, and John Snow's work on its epidemiology; polio, and the Salk vaccine . . . the list goes on. All these advances in medicine changed the answers to questions, and showed that a "fact of life" is often just a problem waiting for a solution.
>
> So it is with the sickness of older age. It has not yet been addressed effectively, but that does not mean that it cannot be addressed. It simply means that we have to find new ways to tackle the problem, and the most promising of these is rejuvenation biotechnology.[277]

Those who would argue against de Grey's project are rebuffed by him as making a "tragic error" and having an "inadequate imagination."[278] He goes further when he states that humans "have a duty to our descendents" not to "condemn countless millions to an unnecessarily early and unnecessarily painful death." Delaying the momentum of anti-aging research is not just unsavory to de Grey, it is "guilt that today's humanity will shoulder."[279]

What none of these biogerontologic therapies tackles forthrightly are questions of meaning, making sense of the current reality of mortality, and consoling ourselves from the miseries that are also an inherent part of the human experience. Ways of making

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[277] Strategies for Engineering Negligible Senescence, "Frequently Asked Questions."

[278] Aubrey D. N. J. de Grey, "When in Doubt, Maximize your Options (Editorial)," *Rejuvenation Research* 14 no. 5 (October 1, 2011): 468.

[279] Aubrey D. N. J. de Grey, "What's Really Delaying the Defeat of Aging?," *Rejuvenation Research* 15, no. 4 (August 2012): 347, 348.

meaning in the present are diminished in favor of problematizing aging as only a scientific problem.

The blind spot of mainstream gerontology and geriatrics regarding elder suffering follows the trajectory of medicine's inability to let go or confront the eschatological narrative and its constricted (though optimistic) vision. Although the eschatology is situated in time (medicine is imperfect in the here and now, but is moving forward toward a more perfect future), the vision is paradoxically ahistorical. Though charged to live in the moment, we are not called to place those moments within a greater social, religious, or historical context. Through this detachment, we lose time's texture and become isolated and alienated from our multiple cultural narratives and sources of meaning. Elders, like all of us, participate in value systems that influence and shape the ability to manage the changes brought by the life course. Like the patients for whom they care, physicians and health-care workers also participate in value networks. Although not always articulated, in the clinical encounter the expectations and desires of both practitioner and patient meet. Understanding the interactions and overlap between these horizons can help practitioners to better understand possible sources of suffering for their patients.

The theologian Stanley Hauerwas argues that the modern experience of aging not only alienates on a societal level, but it can also alienate the elder from herself.[280] As Soelle and Cassell have both observed, disconnection and isolation are two key features of human suffering. Aging is more than a biological event; it is a social one as well. Old age is both a singularly personal experience and a broader cultural one. Traditional interpretations of aging held multiple ideas and expectations of the elder in tension.

[280] Hauerwas, *Growing Old in Christ.*

Elders have never been simply venerated paragons of wisdom; likewise, they have never been known only by their negative stereotypes. They are called upon for advice yet ridiculed for their garrulousness. Contradictions like these become problematic in the way that they each can inform the experience of elder suffering. Ageism is rendered in both positive and negative ways and though the stereotyping is bifurcated, each has the potential to affect the elder. On the one hand, elders must respond to the negative stereotypes that portray them as lazy, dependent, uncompromising, childlike, and even senile. Positive ageism emerges in contradistinction, with vigorous elders shown to be in a state of perpetual youth or middle age. These elders are happy, successful, sexual, productive, and youthful. Images of the Third Age, the time in between retirement and infirmity, make their own demands on elders. Stagnation and decline loom ahead, so those who age cannot rest; rather, they must ignore the physical changes of aging as they maintain former productivity levels.

How can health-care workers let go of medicine's eschatological narrative and begin the work of recognizing, knowing, and addressing their elder patient's suffering? It is to this question that I now turn, using the traditions of the humanities and humanist gerontologists as guides.

INTERLUDE: TURNING TO THE MEDICAL HUMANITIES

Since one cannot—try as longevity experts may—arrest time, elders are invariably subjected to experiences of confusion and helplessness as they try to negotiate time's effects. Actions are often confounded by forces that cannot be controlled. Men and women fool themselves into believing that the world is entirely proscribed, and when that illusion is shattered by catastrophes or just the mundane realization of human limits, they clutch for security within the lived reality of chaos. Though humans live in community, skin physically separates one from another. A person's inner life is singular and particular, and if not articulated, remains incoherent and silent. In short, isolation is a fundamental and inescapable part of the human experience.

Human suffering can develop from a wide variety of causes, but the experience is marked by feelings of desolation, silence, despair through time, and disconnection. The elders who experience ongoing, systematic losses through the death of loved ones, the diminishment of independence, the loss of youth, and the vulnerabilities of the body can feel an abiding, ponderous sense of suffering's depth. Even as they feel the suffering, the way that suffering invokes and cultivates silences makes describing the experience difficult. A poetry teacher who works with elders hints at the difficulty of the veiled suffering of some elders when he writes of the elders in a convalescent home:

> I am struck by the helplessness of the people here. They are mostly in their eighties and nearly all of them have severe health problems. They walk slowly, with pain, have short tempers and have lost the essential dignity that comes with taking care of oneself. Friendships, I imagine, take a long time to develop in such a situation and are often soon betrayed by death. And so it is the social worker who is left the task of dealing with the vast undercurrents of loneliness, abandonment, and rage—undercurrents, because they are almost never directly expressed, but rather appear half-hidden in arguments over petty issues; in

> squabbles about privacy in the shared living quarters; misunderstandings in the dining hall.[281]

Few come out directly and say, "I suffer." Suffering is of the shadows; it haunts a person even as she tries to make the best of her situation. In an effort to help respond to the challenging and threatening emotions that accompany suffering, a natural inclination is to try and tidy up experiences—to make them neater in one's understanding, more manageable, and less chaotic than the experiences really are. The easiest response to the emergent awareness of suffering (aside from the response of ignoring the experiences altogether) is to regard it in a fashion reducible to the ways that it is susceptible to treatments that can help control it. The eschatological narrative of modern Western medicine—a project that concurrently disavows explicitly religious beliefs while utilizing the strategies of organized religions to understand and explain the ambiguous—positions the biomedical complex as a secular savior that is able to deliver people from suffering. The claim to this messianic stature has credibility to the extent that the suffering attended to is simple and manageable. The narrative assures practitioners that they are practicing a pure and true form of medicine. Doing *something* fulfills the desire to provide a measurable accomplishment of the alleviation of suffering.

The eschatological narrative reduces the experience of suffering to a problem of the body or psyche. Within the boundaries of the story, the mysteries of human life are reconfigured as problems to solve, and that will be solved, given enough time. Through scientific discovery, made manifest by the use of intellect and the rational mind, humans will save themselves from illness, disability, aging, and mortality. The narrative

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[281] Roland Legiardi-Laura, "About Ending," in *The Uses of Reminiscence: New Ways of Working with Older Adults,* ed. Marc Kaminsky (New York, NY: Haworth, 1984), 108.

diminishes the varieties and depths of suffering even as it ignores the complexity of human experience. Additionally, the constricted hope maintained through the story cannot encompass or address the contradictions of aging—suffering and joy, potential growth of wisdom at a time when the body weakens, and satisfaction despite the ineffability of death.

Elders and practitioners alike can become victims of the false hopes and overreaching claims extended by the eschatological narrative. The barriers to discovering the soul's deepest burdens are tremendous, and practitioners, with those they would treat, are in fact bewildered by the shadows of mystery and inexplicability that comprise the whole of human experience. Patients, without philosophical, religious, or humanist means for consolation in light of illness and vulnerability, demand that their anxiety be met with medical technology. Practitioners, without vocabularies for addressing the deep unease that rests under patient demands, respond with the therapies and drugs: material interventions that have apparent and measureable effect.

One humanist gerontologist and medical anthropologist, Sharon R. Kaufman, comes close to recognizing the eschatological narrative in her essay in *A Guide to Humanistic Studies in Aging*. She notes the many ways that older Americans can alter the "normal" life span, from the management of chronic disease with pharmaceutical interventions to medical interventions in intensive care units and even hospice care at home.[282] She recognizes the hope of the "biotechnological promise" but is concerned that these methods of caring for the body present a "socioethical problem space" in which

[282] Sharon R. Kaufman, "The Age of Reflexive Longevity: How the Clinic and Changing Expectations of the Life Course are Reshaping Old Age," in *A Guide to Humanistic Studies in Aging*, ed. Thomas R. Cole, Ruth E. Ray, and Robert Kastenbaum (Baltimore, MD: Johns Hopkins University, 2010), 225.

questions of meaning and value are replaced with an idea that the body and self can be "remade" and that subsequent death can be "pushed out into the future."[283]

As the lines between normal aging, natural aging, and pathological aging become increasingly dependent upon and intertwined with geriatric clinical interventions, Kaufman notes that the assumption gets fostered that one "can, and should, choose to intervene."[284] She argues that the significant range of choices open to the American elder shapes how each elder constructs old age. One seemingly could gain years without becoming old, so when the time comes, clinicians, patients, and family members are all put in challenging positions for decision making:

> Clinicians are aware that treatments, for the very old, can be a double-edged endeavor, yet they want and feel obligated to provide life-extending options, sometimes regardless of a patient's extreme frailty. Older people, some of whom are ambivalent about living on and on with deteriorating health and functional abilities, do not usually want to authorize their own death by proactively stopping or rejecting a life-saving therapy. Families do not want the responsibility of saying "No" to life-extending therapies for their loved ones, and, of course, they are hopeful that treatments can extend meaningful life. Finally, our procedure-driven health care finance arrangements guide everyone toward treatments—because they are standard, normalized, and expected. Importantly, it is through the lens of the clinic—the range of medical interventions offered—that more and more of us experience and practice *hope* [author's italics] when we imagine longevity.[285]

The most dreadful effect of the eschatological narrative is that, in its efforts to reduce suffering, it can inadvertently harm both practitioner and patient. Franz Kafka captured this sad cycle in his short story "The Country Doctor," when the doctor-protagonist, harried and miserable, observes that his patients are “always demanding the

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[283] Ibid., 226, 227.

[284] Ibid., 228.

[285] Ibid., 239.

impossible of a doctor. They have lost the ancient faith; the pastor sits at home, unraveling his liturgical vestments one by one. But the doctor is supposed to accomplish everything with his delicate surgical hand."[286] Practitioners and patients, wanting to do *something*, increase their suffering through assimilations to the eschatological narrative and through professions of allegiance to the narrative's unspoken demands and grandiose claims.

Generous and morally rich medical care must be informed by the varieties of human experience, including the challenging feelings of chaos and confusion that are an inescapable dimension of being embodied in a complex and unpredictable world. The practice of medicine is about evidence-based practices, prescriptions, and management of disease, to be sure. At its root, though, the practice of medicine is always about a human caring for another human. The interpersonal relationship is an inextricable aspect of care.

The effects of the eschatological narrative derail the transaction of care in its full sense. The narrative's ability to motivate and inspire have led to remarkable achievements, but its trajectory of false hope has been a major contributor to medicine's inability to address, adequately and ethically, patient suffering. The narrative has insinuated itself into the social imaginary in such a way that it has come to silence other more beneficial and beneficent stories. The eschatological narrative is only one of multiple narratives that are available to the practitioner and patient, but it has become tyrannically oppressive, serving to eclipse other narrative approaches that afford better understanding of elder experience and suffering—and ultimately, then, better care.

Witnessing another human's suffering is emotionally challenging. It can be

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[286] Franz Kafka, "A Country Doctor," in *The Metamorphosis, In the Penal Colony and Other Stories: The Great Short Works of Franz Kafka,* trans. Joachim Neugroschel (New York, NY: Simon and Schuster, 2010), 140.

frightening. Those who suffer hold up a mirror to another's fear of pain, and though no less human, practitioners who have committed themselves to the healing professions cannot avoid or deny their patients' suffering. The eschatological narrative hides suffering in plain sight even as it gives practitioners a way of "helping" the patient while avoiding the deep moral engagement necessary for the accomplishment of real care.

Health-care practitioners are not to blame for their myopia. Even before medical school, practitioners are taught—by mentors, the media, and society at large—to think their way out of the problem of suffering, rather than to cultivate faculties of thought that could help a person know how to *be* with suffering. In her book *Not for Profit: Why Democracy Needs the Humanities,* Martha C. Nussbaum gives an account of how educational goals are being shifted as a result of governments' looking to short-term economic gain rather than the development of moral and "complete" citizens. Across the globe, technical skills that directly translate to economic return are being valued at the expense of those ways of knowing and being that make human relationships rich.[287] During their medical education, students are taught to think with science. Questions of science are typically descriptive and focused upon the biological and the mechanistic body. Always seeking patterns, scientists ask how organisms age, from the molecular level to full organ systems. What lifestyle changes, medical treatments, or therapies could compress morbidity and postpone mortality? How can disability be managed, and how can one describe the processes of aging?

When the descriptive concerns of scientific inquiry and the claims of the eschatological narrative join together, they silence the questions of meaning that are also

[287] Martha C. Nussbaum, *Not for Profit: Why Democracy Needs the Humanities* (Princeton, NJ: Princeton University Press, 2012), 6.

fundamental to human existence. The eschatological narrative becomes a *finalizing* narrative, in the sense that it prevents other narrative interpretations of suffering from being entertained. The accumulation of objective facts becomes the dominant mode of discourse, and other questions of subjectivity become secondary. That which cannot be measured loses value as a matter of concern; alternate ways of knowing become marginalized or ignored altogether.

Narratives imposed by habits of thinking, ideological conformities, or tyrannical powers can force a narrative surrender on the part of persons whose lives are inscribed in them. Since human lives are constituted by narrative construction, though, such narrative surrender dehumanizes people by means of finalizing their narrative self-construction. Even narratives that have good qualities, like the eschatological narrative, are bad when they become oppressive and silence other stories that are needed to capture the complexity of the human experience. Stories should be dynamic entities that reflect the complicated ways of being human in the world.

Thinking with multiple stories can help the practitioner relinquish the eschatological narrative, freeing the practitioner from the finalizing demands of treatment and cure in order to authentically relate to a patient. Through an engagement with the humanist project, practitioners can come to understand the multiplicity of narratives that are available to practitioners—narratives that entertain alternate ways of conceptualizing the meaning of suffering. The eschatological narrative remains a hidden part of the social imaginary, but a number of humanist gerontologists have advanced the study of meaning making as it relates to aging and becoming old. Beyond the questions of how people age,

these scholars examine how the life process informs discussions about ways these elders can make sense of their experiences.

These humanists are engaging in a project that harkens back to the Italian Renaissance, when a group of scholars founded an innovative curriculum, called the *studia humanitatis*, which focused upon educating students' emotions and minds simultaneously. Instead of focusing solely on technical details, the students of the *studia humanitatis* were charged with developing skills for making sense within a contingent and often frightening world. It focused upon a knowledge of letters and a knowledge of those things that relate to moral character and life–those things that "perfect and adorn a human being." [288] For the humanists, studying and learning offered external goods of bettering the self and moving others to right action. The study of letters was undertaken to know the self better so that one could engage with his or her community. Humanists were aware of their roles as public figures within society and were concerned with the external value of their intellectual pursuits. The highest goal of the *studia humanitatis* was the development, growth, and perfection of virtue that was personalized and internalized.

The *studia humanitatis* also developed, in large part, as a direct way of coping with, making sense of, and dealing with radical suffering. Francis Petrarch, called the "Father of Humanism," used reading and writing to help console himself and make meaning out of his tremendous sources of suffering. He is particularly important to this story of elder suffering because he was unabashed in writing about his misery, as well as

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[288] Robert E. Proctor, *Defining the Humanities: How Rediscovering a Tradition Can Improve Our Schools: With a Curriculum for Today's Students,* 2nd ed. (Bloomington, IN: Indiana University Press, 1998), 3.

his methods for coping with his ongoing distress. Though he is removed from the modern world, his descriptions of suffering are insightful and illustrative, and they set in motion a practice that can directly confront the limited meaning ascribed within the eschatological narrative. As such, his writings give an aperçu into the suffering that many endure but do not describe.

Petrarch lived a difficult life despite his great fame. Born in exile, he rose to great heights as a translator and writer, and though he achieved fame in his lifetime, he was prone to perfectionism and depression. Petrarch's descriptions of his sorrows reveal social, psychological, and existential dimensions. In his writings, he admits melancholy and depression, but he also experienced an overwhelming portion of catastrophe and loss, becoming intimately acquainted with the radical sense of contingency brought by a seemingly endless onslaught of traumatic events.

Petrarch's sources of suffering ranged from the personal to the professional, and from the social to the spiritual and existential. Part of his suffering stemmed from the reality of embodiment. Ernest Becker, writing in the 1970s, described the contradiction that so captured Petrarch's attention. Becker says that the essence of man is paradoxical in that he is half animal and half symbolic.[289] We experience the condition of individuality within finitude. In other words, we have a capacity for creation and the ability to perceive ourselves symbolically. Yet, even with our capacity for greatness, our bodies are destined to decay in the ground. Petrarch struggled with this reality. Assuming the voice of Augustine, Petrarch describes the sorry lot of human existence

[289] Ernest Becker, *The Denial of Death* (New York, NY: Free Press, 1997).

and the ubiquity of misery. He captures eloquently the undeniable vulnerability of humans when he has Augustine say:

> Look at him when he is born, naked and unformed, crying and wailing . . . with a frail body, and an unquiet mind, subject to various disease, a prey to innumerable passions, without understanding, wavering between joy and sadness, impotent of will, unable to restrain his appetites; ignorant of what or how much he needs, with no measure in his eating and drinking; obtaining only with great labor that nourishment which is so freely available to the other animals; drugged with sleep, bloated with food, overcome by drink, worn out with watching, reduced by hunger, parched with thirst; greedy and fearful, loathing what he has, lamenting what he has lost; worried about the present, and the past, and the future, all at the same time; proud in his wretchedness, and yet conscious of his frailty; lower than the lowest worm; with a short life; uncertain how short that life will be; whose fate is fixed; and who has so many ways to die.[290]

Beyond the physical reality of embodiment that grieved him, Petrarch experienced further suffering from great bouts of melancholy from which he could not shake loose. In his *Secret Book*, he laments that his "spiritual bane" creates a darkness that feeds upon itself. "This sickness," he writes, "takes such a hold on me at times that I am in torment for days and nights on end; I endure a period, not of light and life, but infernal night and the semblance of bitter death. And (what is the worst of all miseries) I feed on my tears and grief, with a sort of dark pleasure, so that it is only with great reluctance that I can tear myself away from them."[291]

None of the agitations Petrarch experienced, though, were as troublesome as the profound, sustained, and radical losses that he endured during the Black Death. The bubonic plague began its assault upon the European continent in 1348. The disastrous

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[290] Francis Petrarch, *My Secret Book*, trans. J. G. Nichols (London, UK: Hesperus Press, 2002), 36–37.

[291] Ibid., 44.

epidemic spared Petrarch his life but left him to witness the carnage revealed in the wake of the pestilence. The next decade, marked by a litany of deaths and the social suffering that accompanied the epidemic, left Petrarch so sorrowful and lonely that he felt paralyzed and unable to work. For Petrarch, those years felt truly apocalyptic as the plague killed off the majority of his closest friends, family members, and acquaintances, including his beloved Laura, the subject of his famous sonnets.

Petrarch felt helpless in the face of ongoing radical misfortune, going so far as to wish for death to release him from his tormented grief. He personifies his vulnerability as *Fortuna* or *Fortune*, the cruel fate who doles out human destruction. In one of his letters, he writes:

> Oh deceitful hope of mortals, oh useless cares, oh precarious human condition! There is nothing peaceful for man, nothing stable, nothing safe: here we see the power of fortune, there traps of death, and there the flattery of the fleeing world. Do not ever hope for anything or take fortune seriously: she is a liar, she is fickle, capricious, untrustworthy; you have at one time known her flattery and gentleness, but later you have seen her bitterness.[292]

Petrarch's intimate acquaintance with the "deadly monster" of *Fortuna* reflects how he coped with his traumas. In meditation upon his sources of suffering, Petrarch gives insight into his methods of consolation. Burdened with the constant threat of death, tragedy, and a fear of transience, Petrarch experienced his own life as part of what Renaissance scholar Robert Proctor calls the "abyss of contingency."[293]

As a man of learning living in the Middle Ages, Petrarch's suffering from the radical unpredictability of life created a unique dilemma for him. The cultural dictates of

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[292] Francis Petrarch, trans. Aldo S. Bernardo, *Letters on Familiar Matters (Rerum Familiarium Libri): Vol. 1: Books I-VIII* (New York, NY: Italica Press, 2005), 361.

[293] Proctor, 35.

fourteenth-century Italy gave a blueprint for managing the abject misery that he felt; unfortunately, the classical methods provided him no solace. For Petrarch to gain some sense of relief from his suffering, he had to appropriate the teachings of the classical writings in novel ways. In the late Middle Ages, a scholar like Petrarch would have turned toward a certain kind of philosophical and religious contemplation that could supposedly help him tame his emotions. This manner of contemplation connected with the classical understanding of a unified cosmos that medieval men inherited from their ancient predecessors, who believed in an elegant unity of physics, philosophy, and the human soul. The common understanding prior to Galileo held that beyond the moon lay a calm, pure, perfect, and eternal heavenly sphere. Though a part of the whole perfect cosmos, Earth was the domain of change and corruption, turmoil and strife. These earthly matters were not to be the focus of a person's attention; rather, the person, as a part of the cosmos imbued with the ability to reason, should reflect upon the unchanging perfection past the moon. In order to attain peace, one needed only to change one's thinking by using his capacity of reason to modify his opinions. Harmony between the soul and cosmos was the classical ideal and contemplation was the means for a mortal to achieve it.

Petrarch understood well that the use of reason was the method for helping himself to bear the weight of his suffering, but he could not just focus on celestial perfection to make himself feel better. Herein lies the primary difference between the classical and medieval man's methods of consolation and Petrarch's. Instead of turning outward toward contemplation of that which is calm and eternal, Petrarch turned his attention inward, using writing as a way of exploring his inner self. The deep

contemplation of the self was unheard of for a writer in the early Renaissance. Petrarch's consolations came from turning to ancient texts and exploring them for meaning for his own time. Proctor argues that Petrarch's experience of reading was deep, inner, and transformative. He writes that Petrarch "could feel the words in his body. The healing that came from such reading resulted not from being lifted outside of himself, but rather from sinking deep down within."[294]

In the act of writing, Petrarch achieved his own consolations and set in motion a pattern that later humanists would follow and that is used today to help elders make sense of their experiences. Through the process of close reading and writing, Petrarch was able to make meaning of his sense of loss and feelings of vulnerability in the face of merciless *Fortuna*. Even though he was alone in fundamental ways, Petrarch was able to turn backwards towards the past and inward toward himself. By the time that Petrarch died in 1374, humanists had already begun to take on the project of constructing an introspective, personal self that was engaged with society and the greater world. The *studia humanitatis* was a pedagogical foundation for bridging a new internalized conception of the self with the demands of the polis. The curriculum was reflective and transformative, seeking to educate the emotions and engender ways of being that would allow them to tolerate ambiguity and make meaning despite experiences of radical contingency and suffering. Through their learning, humanists cultivated a way of being in the world that attuned them to the matters of the day.

The educational goals of the Renaissance *studia humanitatis* were rediscovered in the 1960s and 1970s by a group of scholars who were also trying to make sense within a quickly changing world. Technological developments within medicine caused certain

[294] Ibid., 44.

practitioners, scholars, and teachers to wonder whether the patient's story was being lost amidst great technical achievements. Humanist gerontologists emerged during this time as well, asking questions about how elders make sense in and of their later years.

Some of these gerontological humanists have explored the social construction of age in historical contexts. Others engage elders in the creation of art through painting, theatrical projects, and creative or reflective writing exercises. Each of these projects helps the elder gain some grasp of the meaning of being old, apart from the biological processes that accompany the advancement of years.

Through the work of these humanists, the finalizing demands of the eschatological narrative can be diminished as a multiplicity of narratives emerges in polyphony with one another. As a corrective to the finalizing mode of thinking brought about by adherence to the eschatological narrative, physicians and gerontologists would do well to cultivate, through education, a capacity for practicing the humanist project, which developed out of the Renaissance *studia humanitatis* and has continued within the practices of the medical humanities. This project can lead physicians to acknowledge the limitations of the eschatological narrative and to address, subsequently, the complex experiences of patient suffering: to address that suffering, this is to say, in a fashion commensurate with the complexity of the phenomenon of suffering. This chapter affirms the role of the humanities within the practice of medicine as the means for revising the eschatological narrative and opening up a broader moral space for the consideration of the questions of frailty, vulnerability, morbidity, and eventual mortality. In the following pages, I shall examine the development of the humanist project: how it intersects with

humanist gerontology and what the literary arts can offer practitioners who want to resist the eschatological narrative's finalizing and silencing characteristics.

The practice of the medical humanities contains within it internal goods that encourage expansive ways of being in the world. Practicing the humanist project, which begins with the particular, singular human experience and continues with dialogue, the close reading of texts, and the therapeutic use of writing can lead practitioners to engage more completely with their patients' suffering. The medical humanities are a site for representation and interpretation of these parts of the human condition that resist classification and measurement. They reveal the invisible narratives, like the eschatological narrative, that affect how we act in the world and, more generally, explain how stories structure our reality. Furthermore, the practice of the humanist project can open up alternative methods of meaning making for elders and their practitioners. The methods can provide a space for the voice silenced by suffering and can infuse the emptiness that characterizes suffering with meaning and even purpose.

The medical humanities are a moral project to the extent that those who practice the medical humanities ask value-related questions. The project is inherently pedagogical, also. In addition to scholarship, those within the medical humanities seek to teach others how to engage with these questions of value in the context of medicine. Ideally, this education would occur early in medical training, so that budding practitioners could start the process of developing the habits of thought that are required to engage with the narrative complexity surrounding illness, vulnerability, aging, and dying. The medical humanities offer no quick fix in the sense that one could interact with a single text in order to appreciate the complicated human experience; rather,

education in the medical humanities encourages moral transformation within its students over time, so that these students may engage with the complexity inherent in multifaceted issues such as human suffering. The texts and methods of the medical humanities offer its students alternative ways of thinking by offering them ways of moving into suffering's silent spaces in order to create new opportunities for dialogue about suffering within the human experience. This process is ongoing, developmental, and challenging, but the rewards can be a more authentic relationship with the patients for whom these students care.

CHAPTER 5: NARRATIVE MEANS FOR RESISTING DIALOGICAL FINALIZATION

Poor naked wretches, wheresoe'er you are,
That bide the pelting of this pitiless storm,
How shall your houseless heads and unfed sides,
Your looped and windowed raggedness defend
you
From seasons such as these? O, I have ta'en
Too little care of this. Take physic, pomp.
Expose thyself to feel what wretches feel,
That though may'st shake the superflux to them
And show the heavens more just.
—*King Lear*, Act 3. Sc. 4, ll. 1831-1839

HUMANISTIC GERONTOLOGY'S CONNECTION TO THE *STUDIA HUMANITATIS*

Modern medical humanists come from a variety of disciplinary backgrounds but share a focus upon moral and pedagogical questions in the practice of medicine and biomedical research. Emerging out of the tumultuous 1960s and coinciding with the development of the humanities within medical schools, scholars who identify themselves as humanist gerontologists began carving a niche as they probed the connection between human values and aging. Recognizing that the study of human aging was focused too much on mechanistic processes, a group of scholars in the 1970s began to address the gap between the scientific body of knowledge that comprised gerontology, the lived experience of the elderly, and the ways that elders construct meaning. The same questions that occupied the Renaissance humanists—questions of value and meaning within a contingent world—occupied the minds of these new, modern humanistic

gerontologists. In their introduction to *Guide to Humanistic Studies in Aging*, humanistic gerontologists Thomas R. Cole, Ruth E. Ray, and Robert Kastenbaum observe that, at that time, "the basic question of humanistic gerontology—what does it mean to grow old?—had not been raised."[295]

Since then, humanistic gerontology has emerged as a site for knowledge production with respect to aging, identity, and meaning. Humanistic gerontologists have undertaken narrative projects that help elders craft their own stories—stories that refuse to be shoehorned into the form of the eschatological narrative. These scholars comprise a small subset within the larger field of geriatrics and gerontology, a field that still succumbs to the pressures of the eschatological narrative, but their work is vital to creating a space in which elders and practitioners can explore the emotions, mysteries, chaos, and wonder inherent with the later years of life. Within these spaces of exploration, practitioners, humanists, and elders can directly engage the questions limited by the eschatological narrative.

Humanistic gerontologists have made inroads in approaching the construction of meaning in creative ways. Understanding the connection between form and content, these humanists offer practitioners and elders ways of escaping the demands of the eschatological narrative's need to tidy up the experience of illness and aging. This freedom allows for imaginative meaning making for the suffering person.[296] From the experience of meaninglessness and powerlessness over time, suffering can come to be

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[295] Thomas R. Cole, Ruth E. Ray, and Robert Kastenbaum, eds., *A Guide to Humanistic Studies in Aging: What Does It Mean to Grow Old?* (Baltimore, MD: Johns Hopkins University Press, 2010), 1.

[296] Michelle Sierpina and Thomas R. Cole, "Stimulating Creativity in All Elders: A Continuum of Interventions," *Care Management Journals: Journal of Case Management; The Journal of Long Term Home Health Care* 5, no. 3 (Fall 2004): 175–182.

infused with meanings—thereby transforming the experience of chaos into one of endurance. Humanistic gerontologists have troubled the term *old*. What does it mean to *be* old? Even the term, *old*, as it relates to human age, is fraught with complication.[297] As I discussed in Chapter 3, the modern category of *old* or *aged* was not always assumed; rather, it emerged as a result of the shifting cultural landscape of the nineteenth century. Humanist gerontologist and literary scholar Anne Davis Basting observes that "life stages follow general parameters through which, if we're lucky, we will all eventually pass."[298] Undeniably, much of the human experience, including the elder experience, can be observed, described, measured, and categorized. *Oldness*, and even the term *age*, are not neutral terms, however. Narrative gerontologist Kate de Medeiros argues that age, and the corresponding term, *old*, can be thought of in at least three ways. Age can be considered chronologically, as simply a person's number of years. The number can have ramifications within society. Car insurance rates, the collection of Social Security benefits, and the age of retirement are all marked by chronological age. Social age, on the other hand, is the consideration of age as the attitudes considered "appropriate" for a person's chronological age. Age can also be considered physiologically—as a kind of medical marker of a person's health and functionality. In this sense, age is described medically, via measurable, definable tests.

The multiple ways of defining *age* reflect the complexity and difficulty of fully appreciating it. Despite all that might be captured by tools and means of measurement and description, the experience of being human still, in many ways, resists understanding

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[297] Kate de Medeiros, *Narrative Gerontology in Research and Practice* (New York, NY: Springer, 2013), 18.

[298] Anne Davis Basting, *The Stages of Age: Performing Age in Contemporary American Culture* (Ann Arbor, MI: University of Michigan Press, 1998), 5.

in its totality and complexity. As a fundamentally human experience, becoming old, too, resists circumscription by reductive understanding. The millions of elders who have transitioned into old age can share their wisdom; yet, having never become old before, every single elder is an explorer, charting a life course unique to him or her. The human experience is messy and mysterious. Fortune, so capricious, can change in a day and leave a person to try and make sense of the senseless.

Educating students and young practitioners in the medical humanities can lead them to developing habits of thought that can aid them in becoming powerful moral witnesses to the suffering of their patients. They can also cultivate ways of being with patients that can resist the eschatological narrative by providing more authentic attention to patient suffering.

The following sections will explore alternative ways in which practitioners can utilize the tools inherent within the medical humanities. The literary arts are a particularly special means for accessing and understanding, in a humanistic sense, the messiest parts of the human experience and can offer counter-narratives to the finalizing eschatological narrative. The relationship between listener and speaker, the writing of nonfiction, and the study of fiction can all be utilized to defy the eschatological narrative's imposition of false hope. These three iterations of the literary arts, when in dialogue with gerontology, fall into two broad categories: narrative gerontology and literary gerontology. *Narrative gerontology* provides a framework for research and practice, including the study of memory and autobiography, the role of stories in clinical practice, and the use of narrative in understanding everyday life.[299] *Literary gerontology*, influenced by cultural

[299] de Medeiros, 33.

studies, examines creative writing and fiction using the lenses of literary criticism in order to understand aging and to examine how aging influences the creative process.[300] Both categories open up spaces for multiple narratives that can provide hope and meaning counter to that of the eschatological narrative. I shall examine both categories in turn, assessing the ways that the skills fostered by an appreciation of the categories can help foster insights for that may help them relinquish the damaging aspects of the eschatological narrative.

NARRATIVE GERONTOLOGY AS A MEANS FOR RESISTING DIALOGICAL FINALIZATION

At its root, narrative gerontology recognizes that all humans think with stories, but, more importantly, stories form the basis for how people think. Human *being* is constituted, fundamentally, by interpretive capacity and action. Humans are social creatures who live with, through, and within stories. The traces of our interpretive endeavors surround people from childhood to elderhood. Humans live within a constant sea of stories; moreover, people are always in the act of putting their lives into narrative form by attaching plot to the moments of their days and choosing the details to share and the order in which to share them.

Through general discourse and interactions in the world, humans are always going through the process of storying reality. This is a process that never ends; as people encounter new experiences and parts of life, they are always integrating them into their stories. Humans are always in the process of shaping and reshaping what is known to be

[300] Cole, Ray, and Kastenbaum, 16.

the "self."[301]

How one structures the story of life exposes value. Philosopher Martha Nussbaum writes, "The telling itself—the selection of genre, formal structures, sentences, vocabulary, of the whole manner of addressing the reader's sense of life—all of this expresses a sense of life and of value, a sense of what matters and what does not, of what learning and communicating are, of life's relations and connection. Life is never simply *presented* by a text; it is *represented as* something."[302] Language structures our thoughts and mediates our understandings of the self, as political scientist Charles Taylor contends.[303]

The telling and hearing of stories is critical to the alleviation of the suffering connected with the imposition of the eschatological narrative. Despite this necessity, suffering is often characterized through its silence and perceived chaos, which makes story telling difficult. Not all stories can be told easily or even coherently, and within the medical setting, clinicians may be unable to guide patients through systematic life reviews. Yet, even the clinical encounter is narrative-based. Speaking and listening are fundamental to the relationship between practitioner and patient.

The sociologist Arthur W. Frank explores the moral imperative to speak and be heard in *The Renewal of Generosity: Illness, Medicine, and How to Live*.[304] Having grown weary of using care as the catch-all phrase for the rehumanization of medicine,

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[301] Ibid., 38.

[302] Martha C. Nussbaum, "Introduction: Form and Content, Philosophy and Literature" in *Love's Knowledge: Essays on Philosophy and Literature* (New York, NY: Oxford University Press, 1992), 3-53.

[303] Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge, UK: Cambridge University Press, 1992).

[304] Arthur W. Frank, *The Renewal of Generosity: Illness, Medicine, and How to Live* (Chicago, IL: University of Chicago Press, 2004).

Frank's goal becomes one of reclaiming the relational aspects of medicine without relying on the care as an umbrella answer. He wants to explore relationships in medicine more deeply and, in doing so, broaden and deepen the moral sphere of medicine. Frank wants to move away from the professional response and into a kind of moral and dialogical engagement that is key to moving beyond the limited response to suffering held within the eschatological narrative.

Frank names *generosity* as the moral concept that can accomplish or make headway toward accomplishing this goal. He argues that generosity should be the primary moral stance within medicine and should be used to increase the moral sphere of those who find themselves as caregivers or the sick. Generosity first involves a welcome. The generous person must move beyond the required and become hospitable towards the other, welcoming those who suffer. The generous person welcomes the other as a guest into a moral space with a sense of constancy that replaces fear of isolation. This moral space must be wide; it must be wide and deep enough to hold the pain, confusion, and existential worry brought about by illness. As in a home, sanctuary, or safe-haven, the guest should feel repose, and the host should encourage this by being responsive to the needs of the guest.

After the welcome, the responsiveness begins with the host (the medical practitioner) creating a dialogical space. Frank places a high value on conversation, but boundaries are placed around his discussion by his assumption that both parties share a respect for the value of dialogue. Stories, says Frank, show us how to be generous. The constructs of the self and the other have been abstracted from the daily lives of health-care workers, and although these constructs are rich, without a connection to the lived

world, they become isolated, tucked far away between the pages of books rather than practiced by the men and women for whom the theories were written. When we think with stories, the stories "analyze us."[305] They elicit emotional responses and provide lenses that inspire, and require, interpretation.

The false hope of the eschatological narrative offers a finality to the options of hope for the suffering elder. Frank writes about and quotes Bakhtin: "Bakhtin understands the human moral essence as people's acute 'sense of their own inner unfinalizability, their capacity to outgrow, as it were, from within and to render *untrue* any externalization and finalizing definition of them.'" [306] To embrace a more dialogical end recognizes the unfinalizability of any story as the human moral essence.

One of the ways narrative gerontologists help older people make sense of their experiences and recognize the unfinalizability of a life's narrative is through the use of life review. Coined in 1963 by the psychiatrist and first director of the National Institute of Aging, Robert Butler, the process of the *life review* is a means by which elders can engage in systematic reminiscences regarding unresolved issues in their lives. It is

> a naturally occurring, universal mental process characterized by the progressive return to consciousness of past experiences, and, particularly, the resurgence of unresolved conflicts; simultaneously, and normally, these revived experiences and conflicts can be surveyed and reintegrated. Presumably this process is prompted by the realization of approaching dissolution and death, and the inability to maintain one's sense of personal invulnerability.[307]

Several characteristics of the life review emerge out of this definition. First, the

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[305] Ibid., 6.

[306] Frank, *The Renewal of Generosity*, 100.

[307] Robert Butler., "The Life Review: An Interpretation of Reminiscence in the Aged," *Psychiatry* 26 no. 1 (February 1963): 66.

process is argued to be a universal process. Butler's conception of the life review challenged the dominant notion that aging was necessarily a pathological process and that storytelling reflected flaws in memory, poor coping skills, or psychological regression. Instead, Butler argued that reminiscence was a natural, developmental process. Though elders have been negatively stereotyped since antiquity with regards to their garrulousness, humanist gerontologists since Butler recognize the importance of storytelling and reminiscence for elders. Like the Roman god Janus, with his two faces looking both backward and forward, the process of reminiscence can help the elder examine his past so that he might bravely face the future.

Second, the life review helps the person "survey and reintegrate" past conflicts. Not simple memory retrieval, this process focuses upon the challenging times of a life in the hopes that peace can be made. Butler was careful to distinguish his concept of the life review from mere reminiscence. He eventually ceded the point that reminiscence would "not constitute 'true' life review unless it entailed a critical assessment of prior events in a subject's life."[308] He was also careful to say that the life review could have negative consequences. Historian and Butler biographer W. Andrew Achenbaum recalls that the life-review process, according to Butler, "could spark feelings of regret, anxiety, despair, and depression, or aggravate neuroses."[309] In subsequent research, life writing has been shown to decrease depressive symptoms among elders.[310]

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[308] W. Andrew Achenbaum, *Robert N. Butler, MD: Visionary of Healthy Aging* (New York, NY: Columbia University Press, 2013), 10.

[309] Ibid., 5.

[310] Beth A. Mastel-Smith, et al., "Improving Depressive Symptoms in Community-Dwelling Older Adults: A Psychosocial Intervention Using Life Review and Writing," *Journal of Gerontological Nursing* 33, no. 5 (May 2007): 13–19.

Finally, Butler claims that the need to review one's life stems, partly, from one's inability to maintain one's sense of personal invulnerability. Indeed, the recognition of helplessness or powerlessness can be a hallmark of suffering. The life review is meant, then, to help one embrace those feelings of helplessness and to cloak one with the bravery to stare fearlessly into the *tremendum*—that abyss of meaninglessness that awaits at life's ultimate limit. Instead of the false hope presented by the eschatological narrative, a hope that is situated in the lie that the body could maintain a certain level of health, the life review can reveal alternative visions of hope, sustenance, and purpose.

These writing or dramatic projects, often accomplished in group settings, help elders reflect in many ways. Elders are given general prompts to use as stimulation for free writing. The elders are invited to share their writing among the members of the group, with the guarantee that the audience will be responsive and welcoming, rather than critical of technical ability.

One of the most important studies of the life review is an edited volume from the early 1980s by Marc Kaminsky.[311] Kaminsky, the founding director of the Artists & Elders Project, brought poets, literary critics, dramatists, and social workers together with elders for innovative ways of performing life reviews. Each of the groups tapped into the creative and ongoing processes of narrative construction. Kaminsky writes that "although the *concept* of the life review is readily grasped, the life review itself usually eludes us."[312] Life review is not necessarily a written activity but includes various kinds of identity work. Kaminsky goes on to say that the

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[311] Marc Kaminsky, *The Uses of Reminiscence: New Ways of Working With Older Adults* (New York, NY: Haworth, 1984).

[312] Ibid., 4.

> life review doesn't take any form we might have expected. Fragmentary, half-submerged, moving quickly from one disguise to another, the hidden figures of thought whose presence I dimly sensed in the workshop now appeared clearly before me. I was face to face, at last, with living examples of the process that Robert Butler had postulated. . . . Here was the heightened awareness of death, and the elegaic feeling-tone; here was the return of repressed memories, associated with conflict and guilt, now recaptured with tremendous sensory vividness; here, finally, was that transfiguring of experience which, like Emily Dickinson's 'certain slant of life, "leaves" internal difference / Where the meanings are.'"[313]

Achenbaum remarks that Butler's article "fired the gerontologic imagination" and indeed, life review has become a virtual industry among those who work with elders.[314] Over 200 publications have focused on life review between the 1960s and 2007.[315]

The writing prompts may or may not inspire nostalgia, allowing the elders to dwell in the space of memory in sentimental ways, or to reject those notions as they make sense of the present. The nostalgia can be personal or collective, as the elders consider the details of their own lives and the wider cultural memories remembered by the group. The writing can also serve as a point of reflecting upon sentimentality and how time mediates memory. Harry R. Moody describes reminiscence as touching "dream time, the eternity beyond history, thus arousing in the old person a meditation on the link between waking time and eternity."[316]

Moody goes on to explore the link between private memory and public reminiscence, and this link is important to the notion of revising the eschatological

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[313] Ibid.

[314] Ibid., 1.

[315] de Medeiros, 13.

[316] Harry R. Moody, "Reminiscence and the Recovery of the Public World" in *The Uses of Reminiscence: New Ways of Working With Older Adults*, ed. Marc Kaminsky (New York, NY: Haworth, 1984), 165.

narrative. He argues that reminiscence is necessary to the greater world because it restores a sense of the passing of generations. He calls the relationships between generations "a primordial fact" that is foundational to the human world.[317] Each generation has a unique history, a "distinct biography" that shapes its identity. Collectively, as members of a generation age they earn perspective as they "gain some glimpse of these giant historical shapes and can also grasp the scale of the unimaginable that history discloses."[318] Moody does not overstate himself when he writes, "To see a single generation's task is at the same time to apprehend an entire historical world."[319] What he means by this is that when members of a generation come to adulthood, they do so in a world that is already determined. Eventually, though, they become the bearers of that history, the ones to communicate their unique historical perspective.

The eschatological narrative engages in the fantasy that generational time could stop in the sense that youth and health could be indefinitely postponed; it robs the generation of its sense of uniqueness and its task of communicating its historical individuality. Moody discusses this narcissism: "The loss of faith in a continuity of a public world, a world beyond the self, defines our present dilemma."[320] Without faith in continuity, practitioners have a faith that they could essentially stop the passing of time, creating a kind of stasis in which aging can be slowed and suffering can be whitewashed. The eschatological narrative narcissistically looks to the self for validation, but that

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[317] Ibid., 161.

[318] Ibid., 163.

[319] Ibid., 164.

[320] Ibid., 157.

validation is misplaced, placed within a false sense of human mastery of the unknowable rather than an appreciation of life's mysteries. Reminiscence through the life review, then, offers a different kind of faith: in the continuity of time and in the collective wisdom of a generation. Moody offers reminiscence as a critical form of guidance. "The telling of the tale is *not* an amusement," he writes. "It is a guidance—the best guidance, perhaps the only guidance, that one generation can give another."[321]

By writing and sharing, the elder engages in performative dimensions of the narrative process. Writing, reading, and interpreting all become features of the creation of a story of elderhood that, by its activity and engagement, resists the finalization of the eschatological narrative by imagining alternative interpretations of suffering. The eschatological narrative positions hope within the promise of medical technology to stave off vulnerability, the effects of aging, and the reality of mortality. Moody demonstrates how life review and reminiscence situate that hope differently, by placing it within the natural passing of time and the relationships between and among generations. The importance of a legacy offers consolation to the suffering person; he or she is not invisible but rather the bearer of wisdom.

But what if one of the suffering parties, for reasons of physical diminishment or illness, cannot converse? What if one just does not want to talk about his story or engage in the life review? How is the clinician to recognize, remember, and hear those who are silenced by suffering and cannot share their story? When a patient is in the bed, silenced by her suffering, the clinician need not give up the model of conversation. He must, however, reconceptualize his understanding of vocabulary and dialogue. Conversation,

[321] Ibid., 158.

as interpreted through the lens of generosity, becomes something much broader than verbal language alone. The importance of moral regard and the power of being-with become paramount when confronted by the absences or lack of health and wholeness. Frank quotes Mikhail Bakhtin, setting the quotatuib away from the rest of his chapter in order to call special attention to it: "The very being of man . . . is deepest communion. To be means to communicate. Absolute death (non-being) is the state of being unheard, unrecognized, unremembered."[322]

Despite silence from the one who suffers, the body still remains communicative in its own way. The danger of Frank's argument is that dialogue, inspired to take place within the generous space, can get subsumed under the rubric of conversation. Philsopher Paul Ricouer, though, envisions everything as text, and as such, anything can be interpreted. Communication involves more than just words. How the clinician interprets the uncommunicative body becomes a moral matter. The body becomes the site of moral obligation, and through listening to the body, the practitioner can enter into the dialogical space without saying a word. In this way, the dialogical space becomes less about dialogue and more about understanding. One may think of this listening as polyphonic, listening to words as well as touch or emotion.

THE USE OF FICTION IN RESISTING DIALOGICAL FINALIZATION

Literary criticism and literary gerontology can offer students the capacities for cultivating this kind of ability to listen deeply. Literary gerontologists use the methods of the medical humanities to demonstrate how varieties of aging are constructed in

[322] Frank, *The Renewal of Generosity*, 12, 47.

autobiography, such as the life reviews discussed previously. They also study how different meanings in becoming old are found within fictional representations of aging. Gaining a kind of narrative competency through the engagement with literary and narrative gerontology helps students learn to hold multiple interpretations in tension with one another, as well as resist the finalizing aspects of the eschatological narrative. Nussbaum, grasping the special ways that fine stories are able to represent complex, emotionally challenging experiences, writes that "certain truths about human life can only be fittingly and accurately stated in the language and forms characteristic of the narrative artist" because "a literary narrative of a certain sort is the only type of text that can state them fully and fittingly, without contradiction."[323] She argues that certain stories are complex enough to be congruent with complicated reality. These narratives are expansive and welcoming enough to allow for an understanding and acceptance of the multiple and conflicting emotions that accompany the experience of being human. Various narratives provide different aesthetic experiences and forefront different voices—stories give voice to the helplessness, isolation, and confusion of suffering. Some stories inspire aesthetic, emotional responses within their readers. Other stories are challenging in the ways that they expect readers to use analytical and inductive skills of reasoning as they make inferences about plots and character decisions. These narratives are needed within the world of medicine to help practitioners and patients elaborate upon and complicate appropriately the eschatological narrative.

[323] Nussbaum, "Introduction: Form and Content, Literature and Philosophy", 5,7. I use the modifier *fine* here as Nussbaum does, referring to works of fiction that are substantial and complicated. I do not mean to diminish the aesthetic or entertainment value of less complicated stories, but rather to forefront those stories that more closely reflect the ambiguities experienced in human life.

Literary gerontologist Anne M. Wyatt-Brown examines the ways that aging and literature mutually inform each other and continue to shape the field of gerontology. Writing in the year 2000, Wyatt-Brown presents five categories that dominated literary gerontology at the time: "(1) literary attitudes toward aging, largely examined from a postmodern sociological perspective; (2) late style and creativity across the life course, using psychoanalytic and biographical perspectives; (3) cultural studies of aging, in particular those that analyze the politics of decline and progress discourses; (4) narrative studies of life review and guided autobiography; and (5) explorations of emotions."[324] Twelve years later, Wyatt-Brown returned to the study of fiction and memoir in aging studies and literary gerontology. She affirms the work of literary gerontologists, claiming the importance of combining research with life stories and fiction. Through this combination, she argues that a multiplicity of stories is necessary for engaging with the wide variety of experiences of aging. Through the reading of many stories, a fuller picture of the range of aging experiences, particularly related to resilience and creativity, can emerge.[325]

Stories serve different purposes for readers, and reading is the primary method for coming to know stories and their functions. A cultivated capacity for reading literature—the narrative competency for which I argue—is a pathway for the geriatric practitioner to engage seriously in comprehending and attending to the limits of the eschatological narrative. Careful, close readings of literature offer the practitioner a view beyond the

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[324] Anne M. Wyatt-Brown, "The Future of Literary Gerontology" in *Handbook of the Humanities and Aging*, 2nd ed.. Thomas R. Cole, Ruth E. Ray, and Robert Kastenbaum, eds. (Springer Publishing Company, 2000), 42.

[325] Anne M. Wyatt-Brown, "Resilience and Creativity in Aging: The Realms of Silver" in *A Guide to Humanistic Studies in Aging*, 57.

false hope of the eschatological narrative by engaging with alternate ways of engaging the suffering person as well as various ways of making sense of the experience of suffering. Through literature, the practitioner can encounter any number of worlds. While not guaranteed, the consequences of these journeys can be an increased capacity for reflection, imagination, and what the poetTess Gallagher calls an "intensity of empathy."[326]

Through the reading of fiction, a person has unique interactions with language, experience, and representation. Well-crafted stories capture attention and the imagination in provocative ways. Reading allows one to permeate another's seemingly impenetrable boundaries, giving way to the uncovering of the elusive nature of suffering. Instead of simply examining the suffering of patients clinically, with the sterility afforded by clinical distance, readers can instead bracket their own corporeality and sense of self and enter into the life world of another. They can dwell in another world, if only for a short time. The effect of learning to read well, then, can enable the practitioner to serve as a better "reader" of their patients' suffering. The practitioner who has cultivated his or her moral imagination through reading and wide exposure to representations of human suffering can draw from those stories as he or she cultivates a stance that serves as a moral witness to the patient in front of him or her.

A reader comes to a text with assumptions, predilections, and past experiences. Readers are empowered to move in and out of texts, using their imaginations to enliven the worlds described in pages, though no reader can fully remove himself and his own experiences from the story that she reads. A reader brings his life as background to the

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[326] Tess Gallagher, "Foreword," *Beyond Forgetting: Poetry and Prose about Alzheimer's Disease*, ed. Holly Hughes (Kent, OH: Kent State University Press, 2009), xix.

experience of reading and thus connects a narrative to a lived life. The finest stories burrow into the psyche, continuing to have effects upon the reader after the covers have been closed. These stories become integrated into the person, helping shape the reader's self into something it was not prior to reading. Robert Coles writes that "[a novel] can . . . insinuate itself into a remembering, daydreaming, wondering life; can prompt laughter or tears; can inspire moments of amused reflection with respect to one's nature, accomplishments, flaws."[327]

Stories call out to people in different ways. Not all stories are equal, and all stories do not resonate with readers in the same way. Without having been exposed to many different stories, people will continue to think narratively. They will do so, however, in a way that makes primary the few stories that they have at hand. Without an exposure to a variety of stories, people will be necessarily limited in their ability to recognize and revise the eschatological narrative.

THE METAPHOR OF FRIENDSHIP FOR CULTIVATING NARRATIVE POLYPHONY

Wayne C. Booth uses the metaphor of friendship to consider how readers interact with stories, as well as how they can measure stories' worth. In considering how to think beyond the finalizing eschatological narrative, the metaphor of friendship is helpful for entertaining a multiplicity of narrative voices. Stories, to Booth, are best understood not as problems or riddles to unravel but as friends who offer different gifts. Booth, taking

[327] Robert Coles, *The Call of Stories: Teaching and the Moral Imagination* (Boston, MA: Houghton Mifflin, 1989), 128.

his cue from Aristotle's positioning of friendship as the greatest moral virtue, believes that the quality of a life can be determined, in part, by a person's friends. A person whose deepest allegiances are to fine companions can be said to have had a richer life than one whose trusted confidants are only scallywags. So it is with stories. Those who dwell in unreflective spaces, accepting inherited cultural stories without question, are poorer than those who live with many fine narratives.

Booth names three kinds of gifts that any friend offers: pleasure, profit, or company that is both good for the two companions and good in and of itself.[328] "The fullest friendship," Booth argues, "arises whenever two people offer each other not only pleasures or utilities but shared aspirations and loves of a kind that make life together worth having as an end in itself . . . A true friendship is . . . a relation of strength with strength and aspiration with aspiration."[329]

Within the pages of literature, readers encounter innumerable offers of friendship. Some stories offer aesthetic experiences; others give directions and lessons; still others give intense, sustained pleasure. Each of these types of offers can be integrated into the practitioner's world, giving practitioners varied ways of thinking about suffering and elderly patients—and, subsequently, a better capacity for caring.

The practitioner with a cultivated proficiency in reading can enter the worlds of elderly patients and reflect upon the nonmedical implications of medical decision making. The practitioner can, then, see examples modeled, ranging from excellent care to dangerous malpractice. The relationship between the storyteller and the reader does

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[328] Wayne C. Booth, *The Company We Keep: An Ethics of Fiction* (Berkeley, CA: University of California Press, 1989), 173.

[329] Ibid., 174.

not contain the embarrassing stigma of asking a genuine person personal questions—a difficulty made harder by the silencing and threatening features of suffering. Entering into the vicarious worlds of elderly people through the use of literature can teach practitioners about the lived experience of aging beyond only physical changes. Gaining a foothold into this experience can teach practitioners in a nonthreatening way about the spectrum of experiences for their patients and challenge assumptions that they may have about the aging process as it is experienced socially.

The stories read need not be about medicine in particular, though, to be good friends to readers who are providers of medical care. Engaging with literature exposes readers to other worlds and lets the reader contemplate the details, nuances, and particularities of those worlds. Instead of generalizing about the ways of the world, literature delights in paying attention to the idiosyncrasies that make each person's life unique. Fine works of fiction, both in long form and sometimes even in complicated shorter works, often resist simplification. In a text seminal in the development of the subspecialty of literature and medicine, "The Wonders of Literature in Medical Education," Joanne Trautmann discusses the interpretive methodology of close reading. Through the reading of complex texts, students hone skills of piecing together fragments of stories, working with incomplete information and becoming familiar with both inductive and deductive methods of reasoning. Banks also makes a case for the way in which literature can illustrate aspects of life, but more importantly, the ways that literature *illuminates* life. Literature suggests conclusions about life, in the same way that patients may suggest conclusions about their disease or their sources of suffering. Fine literature uses formal techniques that shed light on the ambiguous: not necessarily

explaining the nuances, but allowing the reader to both come to the mysterious, revel in it, and the step back to reflect upon it. As she writes, "A first-rate fiction is never really *about* anything . . . but only by seeing this detail in subtle and ambiguous and rich relation to that detail, can we get the flashes of illumination that may bring to the student's medical practice a better insight than that which a narrower education offers him or her."[330] Deep appreciation of particularity cultivated through reading can translate into a practitioner's better tailoring what she constitutes to be care. Frank notes that the illness experience is particular and that care begins when the health-care worker recognizes difference and begins to adjust her response accordingly. It begins when one resists generalizing anyone's experience.[331]

Literary "friends" have instrumental value in the ways that they teach readers to cultivate analytical skills of mind. Reading often provides a safe outlet for working through messy emotional situations and moral quandaries.[332] Since readers can move between real life and the world of the text, they can reflect upon consequences of characters' good and bad decisions. They can explore values radically different from their own. Readers who might never have articulated or defended their own moral preferences are given space for defining their views in relation to ones presented in the stories they read.

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[330] Joanne Trautmann, "The Wonders of Literature in Medical Education," in *The Role of the Humanities in Medical Education*, ed. Donnie J. Self (Norfolk, Va.: Bio-Medical Ethics Program, Eastern Virginia Medical School, 1978), 35.

[331] Arthur W. Frank, *At the Will of the Body: Reflections on Illness* (Boston, MA: Houghton Mifflin, 1991), 45.

[332] No literary piece is neutral, however, and works are not equivalent in terms of determining what matters morally. The question of whether any story (or piece of art) could be morally bad for a person has been taken up by such scholars as Booth in *The Company We Keep.*

In addition to its instrumental value, literature has the power to elicit emotional responses from readers that can engender more thoughtful consideration of the moral world. For millennia, fine literature has addressed moral questions of suffering, suffering in aging, and suffering in illness. Sophocles explored isolation and misery connected to illness in his play *Philoctetes*, during the Peloponnesian War, approximately four hundred years before the Common Era. Through the suspension of reality and entering into textual worlds, readers or viewers are able to engage deeply with Philoctetes' feelings of intense isolation. Though his foot has a stinking wound that creates physical pain, the audience is forced to reckon with Philoctetes' deep suffering, which is fed by his experience of profound loneliness and hopelessness. The character has been so isolated as to be out of the world of humans altogether, and the audience is taken along as Philoctetes articulates his cries.

Literature attends to a kind of emotional knowledge, which Nussbaum believes is wed to deep moral knowledge. Morality, according to Nussbaum, cannot be divorced from the emotions. On reading poetry, Gallagher reflects that "with the poetry I love most—it makes me feel the condition of another. It often teaches me how to leap beyond the seemingly insoluble quandaries or situations. Poems carry us to the extremes of sorrow and unexpected joy, even as we search for meaning."[333] Nussbaum argues that works of great literature can "move us to wonder by their complex beauty."[334]

The metaphor of literature as a friendly companion helps illuminate the kind of experiential learning that comes out of being with another. Within the text, distance can

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[333] Tess Gallagher, "Foreword."

[334] Martha C. Nussbaum, "Perceptive Equilibrium: Literary Theory and Ethical Theory" in *Love's Knowledge: Essays on Philosophy and Literature* (New York, NY: Oxford University Press, 1992), 171.

be diminished akin to the closeness that can develop between friends. Through reading, one can share with the text experiences that are warm or emotionally intimate. "Knowledge of the heart must come from the heart—from and in its pains and longings, its emotional responses," writes Nussbaum.[335] The literature that inspires emotional responses within it produces a knowledge that is different from that which comes from analysis alone. This knowledge is discovered within relationship and the feelings that are invoked from it.

Assessing experiential knowledge is difficult in the sense that these lessons are not gained through strictly didactic means. Rather, this knowledge is developed and acquired through mentorship and the richness of experience. Carefully selected literary works can serve as mentors that engage the readers and give them sorts of experiences that mimic the immediacy of actual life. By entering into worlds radically different from one's own, one can expand one's imagination. Literature gives the reader the vicarious experience of being with another culture or having different beliefs, values, ethnicities, or genders. In the act of reading, readers can step in and out of the text, comparing and contrasting their own experiences with those found in the pages. They can move between worlds, comparing them to our own.

By combining various forms of literature, students can imaginatively think about situations that have not yet experienced, or may never face. In the foreword of an anthology of African-American literature on health, illness, and aging, Dr. Edmund Pellegrino offers an example relevant to young clinicians working with minority elders: “How in the world, for instance, is a white, middle-class, twenty-five-year-old male

[335] Martha C. Nussbaum,"Love's Knowledge," in *Love's Knowledge: Essays on Philosophy and Literature* (New York, NY: Oxford University Press, 1992), 262.

doctor, who wants to perform his role in the most intelligent and beneficent way, to approach a poor, aging, folk-educated, black female patient? . . . Without some concerted appreciation of that woman's differences from him, he may not make a healing connection with her."[336] The reflective skills developed in the reading of literature can help cultivate an appreciation of difference. With this appreciation, one can also foster a sense of humility and even reverence, borne out of the awareness of the limitations of perspective.[337] In my final chapter, I examine three examples of narratives that can be used to demonstrate the kind of literary friendship that moves the pracitioner beyond the eschatological narrative. Rather than having a prescription for addressing suffering, the practitioner can cultivate a way of being in the world that approaches suffering in creative ways.

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[336] Edmund Pellegrino, "Ethinicity and Healing" in *Trials, Tribulations, and Celebrations: African-American Perspectives on Health, Illness, Aging, and Loss*, ed. Marian Gray Secundy and Lois La Civita Nixon (Yarmouth, ME: Intercultural, 1992), xix-xxiii. The appreciation of difference is critical, because of the dangers that are also inherent in attempting to "know" another's story. The assumption that one fully understands another's experience is dangerous and can do violence to the person whose story is silenced or whose story is coopted by another person's interpretation of that story.

[337] Paul Woodruff, *Reverence: Renewing a Forgotten Virtue* (New York, NY: Oxford University, 2002).

CHAPTER SIX: THREE EXAMPLES OF LITERARY FRIENDSHIP

Different kinds of literary offers of friendship will demonstrate how narratives can be helpful guides for practitioners who want to break free from the tyranny of the eschatological narrative. I have chosen the Hebraic story of Job, the narrative tradition of Buddhism, and the Shakespearean play *King Lear*, as examples for the modern day practitioner. Each of the stories I picked has something to teach about the experience of suffering and how one can learn to attend to it in creative, empowering ways. They have personally taught me new lessons about engaging with suffering.

These are stories that are old, even ancient, and have taught hundreds, if not thousands, of students across generations. Why use such dusty stories to teach health-care practitioners when other, newer ones might be available? What makes them important narratives to put into dialogue with the eschatological narrative? I do not deny that newer texts can also be fine literary companions, but I choose these older stories as my examples for a number of reasons.

First, the historical longevity of my examples speaks to their power to engage readers across time. These stories can be discovered by each new generation. In the same way that Petrarch gave his own current interpretations to ancient texts so, too, can health-care practitioners look backwards in order to understand the present. As literary companions, they have traveled with readers many times, proving them amongst the finest friends and teachers because of the many generations of students who have discovered and rediscovered them. Second, these stories connect us to our collective cultural history; they show readers that the struggle with which they engage is neither

new nor unique. There can be a shock of recognition for readers who engage with stories that—though old—are still prescient and relevant in the modern world. From ancient times, to the Renaissance, to the current era, these texts demonstrate that suffering has always been part of humanity. For an experience as isolating as suffering, these stories are powerful reminders of community.

This thread of connectivity can be important for students and practitioners who are so engaged with the latest developments in technology and scientific discoveries. Third, the venerable texts that I have chosen remain provocative choices because they dare to stare into suffering's perceived abyss of meaning. These stories articulate the experience of suffering in important ways that differ from the constricted hope offered by the eschatological narrative. The stories of Job and Lear are powerful because, in the moment of directly engaging suffering, they offer a point of resistance. Rather than *doing* something to fill the void, as the eschatological narrative demands, these stories offer a kind of different presence—one that embraces ambiguity and relinquishes control over the experience.

These three narratives are presented in different forms, representing different models for narrative learning. The Book of Job is a straightforward narrative with plot progression; the Buddhist tradition is a first-person-plural narrative with lyric progression, co-constructed between teacher and student; and *King Lear* is a play, meant to be viewed in community.

I have chosen The Book of Job and wisdom texts from Buddhism because sacred texts of the world's religious traditions and the scholarship of interpretation that accompanies them can be important teachers for practitioners, even those who do not

adhere to their metaphysical faith claims.[338] These narratives, including the Book of Job and the texts of the Buddhist traditions, have long given descriptions of survival, meaning, and human excellence.[339] The texts are storehouses of reflections upon beauty, love, and cultural memory. In both Western and Eastern traditions the narratives use allegories, metaphors, symbols, and myths to impart life lessons to the reader, and literary scholars have studied these texts as pieces of literature, analyzing their narrative form and content. Narrating the emotions of the details, these texts witness the concerns, losses, and triumphs of peoples throughout time. The stories give testament to deep political, spiritual, and emotional human suffering as well as provide alternative responses to suffering, illuminating provocative ways in which experiences as negatively powerful as suffering can contribute to deep human flourishing. The texts of the wisdom traditions recount tales of heroic characters and figures that inspire or fall short of moral virtue. These traditions often reinterpret the meaning of suffering as strengthening or educational can be helpful guide1s to thinking about suffering in more capacious ways. The Book of Job serves as a representative example.

Stories that come out of the Buddhist tradition are also helpful companions in thinking about how one can be one's own source of consolation in suffering. Buddhism, one of the oldest systematized religions in the world, has been practiced in various forms

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[338] The Buddhist lama and political activist Thich Nhất Hanh gives an invitation to those of other faiths (or no faith) to consider the teachings of Buddhism in a charming way when he says, "Buddhism is more of a way of life than a religion. It is like a fruit . . . eating a mango does not require you to abandon your habit of eating oranges." Practitioners can learn and grow from the wisdom of these writings without abandoning a rational, scientifically informed world-view. Thich Nhất Hạnh and Jennifer Schwamm Willis, *A Lifetime of Peace: Essential Writings by and About Thich Nhất Hanh* (New York, NY: Da Capo Press, 2003), 158.

[339] Here I speak of religious traditions, as opposed to feelings of personal spirituality that may or may not find place within the historical traditions.

since the sixth century BCE. The religious system itself can be regarded as a narrative, since its teachings are largely transmitted through storytelling. The tradition is inherently hermeneutical: one could conceive of it as a kind of first-person-plural narrative with lyric progression, coconstructed within the dialogue amongst teachers and students. What I mean by this is that the tradition is concerned less with matters of change, in terms of narrative plot progression, and more with self-transformation. Its stories are meditative and focused upon understanding the nature of reality and the self. Lyrical progression as a rhetorical style, writes literary scholar James Phelan, identifies two main modes: "(1) somebody telling somebody else (who may or may not be present to the speaker) or even himself or herself on some occasion for some purpose that something is—a situation, an emotion, a perception, an attitude, a belief; (2) somebody telling somebody else (who may or may not be present) or even himself or herself on some occasion about his or her meditations on something."[340]

The audience of such writings or teachings participates in the meditations and lessons. Phelan continues, "While we recognize that the speaker is different from us, we move from that recognition toward fusion with the speaker."[341] Phelan then goes on to say "lyricality . . . is neutral on the issue of change for the speaker—it may or may not be present—and invested not in character and event but in thoughts attitudes, beliefs, emotions, specific conditions."[342] The authorial goal is that the audience gain a "deeper

[340] James Phelan, *Living to Tell about It: A Rhetoric and Ethics of Character Narration* (Ithaca, NY: Cornell University Press, 2004), 162.

[341] Ibid.

[342] Ibid.

understanding of and participation in what is revealed" through the writing.[343] The wisdom writings of Buddhism are intended to bring the reader to a deeper understanding of himself or herself through immersion within the stories and the subsequent exegesis that emerges out of conversations with teachers and other students.

Performing arts bring in the visual and allow images to speak to audience, allowing a different type of discourse to comment upon social and cultural conditions. *King Lear* serves as an example. The author of the play comes into triad with the director and audience, creating three points to the interpretive triangle. In the way that the reader response completes the relationship between a novel's author and reader, the audience response completes the relationship with the playwright. The lifting of a work off of a page and onto a stage invites multiple possibilities for directorial interpretation. In watching the play, one may identify with one character in one viewing, and another character in another viewing.

The stories of Job, the Buddhists, and Lear, in dialogue with one another, present a variety of ways that suffering can be interpreted: as educative, strengthening and humbling. In none of the stories is suffering reduced to symptoms in need of management or as an experience that must be mollified with platitudes, machines, or pharmaceuticals. These stories present a more authentic interpretation of suffering than that which is offered by the eschatological narrative.

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[343] Ibid., 163.

THE BOOK OF JOB: LEARNING FROM THE WHIRLWIND

The story of Job is particularly relevant as a story that can be a good companion for health-care providers. Suffering has a long presence in the Judeo-Christian texts and in the theological literature analyzing theodicy. Deuteronomy gives voice to many forms of suffering, describing many different physical and mental maladies, but generally connects them all to the displeasing of God in some way. The first book of Psalms echoes Deuteronomy's message: "Happy are those who do not follow the advices of the wicked . . . in all that they do, they prosper."[344] The way that the Hebrew Bible approaches suffering is much more complex, though, than simply as a rewards-and-punishment system. The Book of Job, written sometime between the sixth and fourth century BCE, can stun the reader even today with its powerful expression of the suffering of the righteous. Stephen Mitchell's poetic translation of the Book of Job gives fresh breath and interpretation to the four-thousand-year-old legend.[345]

The story centers around the protagonist, Job—an utterly blameless man. He is affluent and boasts the ancient signifiers of success: he has a wife, ten children including seven sons, thousands of livestock, much property, and the ability to host huge feasts for large groups. Job is also pious; to atone for his sons' *potential* impure thoughts, he

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[344] Psalm 1 in Michael David Coogan, Marc Zvi Brettler, and Carol Ann Newsom, *The New Oxford Annotated Bible with the Apocrypha, Augmented Third Edition, New Revised Standard Version* (Oxford, UK: Oxford University Press, 2007).

[345] Stephen Mitchell, *The Book of Job* (New York, NY: Harper Perennial, 1992). Mitchell translated the book into poetic verse, taking some artistic liberties with the translation in order to convey the spirit of the original text while making the language current and emotionally compelling to a modern audience

presents preemptive burnt offerings to God. In the space of a few lines, the reader is left without a doubt that Job is a righteous man who is undeserving of misery.

In the prologue a kind of bet is established between God and the Adversary.[346] The Adversary bets that Job is righteous only because he has been blessed by God; the Adversary believes that he can prove that Job's love of God is conditional. If all of Job's blessings were removed, the Adversary argues, Job would curse God. God accepts the dare and says that the Adversary can test Job in any way, with the exception of death. Job thusly becomes a pawn in their cruel game as God continues to allow the Adversary to inflict damage upon Job. Over the course of the story, the reader accompanies Job as he tries to make sense of the disasters that befall him.

Mitchell also includes a fine essay preceding his translation that explores Job's transformation through his suffering. The reader can recognize the atrociousness of Job's torment because he so honorable. Job lives with the profound anxiety of knowing that the world is unstable and that everything he had built up over the course of a life could be taken away from him in an instant; just as he dreaded, Job's worst fears come true. No amount of burnt offerings could prevent his reversal of fortune. His suffering is undeserved, and his pleas for forgiveness and explanation are dismissed by "the unnamable" entity of God as pretentious. The unnamable then goes about stripping Job of all the trappings that make up Job's existence. Job undergoes the systemic loss that characterizes suffering when his children, home, property, and health—everything that gives him self-worth and relational stature—are taken from him. He is stripped down to his stark humanity, and no amount of repentance can improve his lot. With everything gone, he cannot turn away from his vulnerability; he must face his fears and angst. The

[346] Often considered to be Satan, *Adversary* or *Accuser* is a more accurate translation.

visceral and overwhelming anguish that Job expresses gives poetic voice to the excruciating anguish that each suffering person experiences. Mitchell describes the chaos of Job's emotional states in his essay:

> [Job's] speeches are a kaleidoscope of conflicting emotions, addressed to the friends, to himself, to God. His attitude shifts constantly, and can veer to its direct opposite in the space of a few verses, the stream of consciousness all at once a torrent. He wants to die; he wants to prove that he is innocent; he wants to shake his fist at God for leaving the world in such a wretched shambles.[347]

When Job finally confronts God in the story, the voice of "the unnamable" comes from inside of a whirlwind, personifying the chaos of human suffering.

The wisdom within Job's story comes not just from its incredible articulation of the feelings of helplessness and nakedness in the face of incomprehensible suffering. The reader is able to entertain different kinds of consolation and witness how those offers affect Job's experience. The reader also experiences, through the ancient poetic text, the thing that brings Job relief, a wisdom that is borne out of the suffering and the deep perceptions of the limits of human understanding.

Job's friends offer well-intentioned but unhelpful advice that exposes their own fears more than it comforts Job. The advice reflects the kind of impoverished help that people sometimes offer when they know nothing else to say. Job's friends try to answer the question *why*, grasping for some reason that Job should have to experience his tribulations. Near the end of the story, the reader, having heard Job's woeful lamentations as well as the weak solace of the protagonist's friends, follows Job as he has the

[347] Mitchell, xvi.

opportunity to query and interrogate the chaos. The Biblical character expresses his moral outrage at this entity who would call itself just but allow such disparity.

Job's encounter with the whirlwind affords him a kind of particular, special knowledge. Job is put in his place by the voice of the whirlwind, which demonstrates to Job that mortals have no capacity for comprehending, much less understanding, the magnitude, awesome "beauty and dread" of what lies beyond human awareness—the *tremendum*. Like a blade of grass that has no capacity for understanding the complexity of human existence, the human cannot begin to understand the enormity of the creations of the unnamable. Job cannot comprehend this lesson simply by hearing the voice of the whirlwind, however. He must enter into the whirlwind and encounter the presence there with his own eyes. Even the figure Moses, the seminal prophet who is known traditionally to have given the Law to the Jewish people, experiences God as a burning bush. In encountering the whirlwind, however, Job actually gets to *see* the unnamable and catch a glimpse of the brutal reality, a balance that cannot be simplified to any facile distinction between good and evil, male and female, or light and dark. The destructive God-features coexist with the peaceful ones; this force must not be judged by the same moral standards known by humans.

Job, recognizing his limitations, is overwhelmed. Mitchell translates the verses this way: "I had heard of you, but now my eyes have seen you. Therefore I will be quiet, comforted that I am dust."[348] Job has seen what appears to be an enigmatic honor or the horror of the sublime enigma of the divine; he has apprehended the force of God in all of its terrible, beautiful, ordered chaos, and recognized his place within it. Job is humbled

[348] Ibid., 88.

but not out of ignorance. He has the awesome knowledge of the world and realizes that the comfort of the ego is not the method of consolation. Awareness of his very humanness is the thing that gives Job the solace he has demanded of the unnamable. Job's story is one of spiritual transformation through his suffering.

Read as a story instructive to medicine, the Book of Job has great power for all physicians as an artful illustration of how one copes with the losses and changes that occur with aging, illness, and the development of disability. Physician Ilan Kutz has read the story in this way, discussing how Job adapts to the assaults made to his physical body. He identifies Job's losses as similar to ones that felt by a sick person who has moved into the chaotic world of illness and is struggling to adjust. He likens Job's laments and rage as Job moving through psychological stages of grief, coming to accept his reality after encountering the whirlwind. Kutz also imagines Job's friends as his doctors who fail in their empathic responses, comparing the ways that Job's friends blame Job for his afflictions with clinical examples that illustrate the ways that physicians fall prey to their own fears of helplessness and, consequently, turn to anger or blame of their suffering patient. [349]

BUDDHISM: SUFFERING AND IMPERMANENCE

What Buddhists call the four noble truths all center upon on the awareness and acceptance of human suffering. Humans suffer in extraordinary ways, but Buddhist

[349] Ilan Kutz, "Job and His 'Doctors': Bedside Wisdom in the Book of Job," *BMJ* 321, no. 7276 (December 23, 2000): 1613-1615.

wisdom calls attention to the mundane and ordinary ways that suffering permeates life. All parts of human existence, to the Buddhist, are suffering (the Pali word, *dukkha*), but this claim is not to be interpreted as entirely pessimistic. Rather, the human being lives in a deep state of dissatisfaction, stemming from the human's inability to achieve permanence. According to Buddhist wisdom, the self is an illusory aggregate of impermanent elements (body, feelings, perceptions, mental states, and consciousness). Suffering develops from the conditioned state that humans have in understanding themselves as an individual: an "I" that exists throughout time, stable and immutable.[350] Since the very nature of the self and its existence are impermanent, humans are always already predisposed to suffer. All mental states—for example, happiness, sadness, sickness, or disappointment—are transient. The bonds of time necessitate that life is always in flux, and the yearning for permanence is misplaced and dangerous because it can never be achieved. In attempting to make any emotional state last, humans create the conditions for suffering.

Buddhist cosmology varies greatly from the Judeo-Christian historical understanding of a singular life and death contextualized within a linear history. Still, without adopting its cyclical faith claims of death and rebirth, clinicians and patients can find important insights for responding to suffering through the study of Buddhism. Buddhist practice brings with it the wisdom of mindfulness, the cultivation of serenity, and acknowledgment of the inter-being of all living creatures and nonliving entities.

To free oneself from the cycle of continually experiencing the effects of emotional states, including those that feel chaotic and overwhelming, Buddhist wisdom

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[350] Walpola Sri Rahula, *What the Buddha Taught,* 2nd ed. (New York, NY: Grove Press, 1974), 19-20.

teaches ways of moving away from the desires of permanence in order to find a way of radically accepting the present. Mindfulness is one of the most important techniques for alleviating suffering. By acknowledging viscerally that no emotion or situation is permanent, one need not attach emotion to any given event. Rather, one can fully embrace *each* moment, feeling the emotions that accompany any given instance but recognizing that each emotion is just another in a long series of transient feelings. Though one may feel overwhelming emotion, one need not let such feelings dictate decision making. By slowing down and inquisitively interrogating each emotion, one can attain some emotional distance from the formidable, frightening experience of suffering.

This practice of slowing down one's thinking and being detached from acting upon emotion can be practiced at any time. Any moment can become an occasion for mindfulness. Even the trivial routine activities like daily chores can be transformed into moments that are enacted to be mindful of one's relationship to the ubiquity of suffering. The Buddhist monk and activist Thich Nhât Hanh tells a lyrical story of how dishwashing can be a mindfulness practice. Humans often have a natural tendency not to want to engage in unpleasant chores because they are boring acts that fill time and keep people from pursuing activities that would bring more immediate pleasure. Instead of grumbling about the dirty dishes, people can recognize the unpleasant feelings attached to the necessity of completing chores. By attending to those feelings in a curious way, then detaching from them, people can remind themselves that whatever is unpleasant will eventually pass, even as the more pleasant emotions that they crave, too, are fleeting. They can then place their attention fully into the present moment and become immersed with the sensations of hands submerged in the warm water, the colors of the soap

bubbles, and the tactile sensations of the wet sponge in a hand. They can be reminded of the cycle of that water, where it came from, and how the water will continue to nourish and give life in generations to come. They may think of all of those suffering in the world because of a lack of clean drinking water. They may be moved to consider how those who suffer in other parts of the world shed light on his or her own sources of suffering. Spending time meditating on dishwashing is one example of how people can become immersed or absorbed into a narrative, participating in the hermeneutical act of constructing a story that gives meaning to a seemingly inconsequential task. In these moments, absorption within the story is a kind of hermeneutical way of being in the world; it is a stance that opens one up to a different way of relating to the wider world. Something as mundane as cleaning some supper plates can be a point of reflection on the suffering in the world and the world's interconnectedness.[351] Suffering in this instance becomes educative and creative, inspiring one to move out morally into action.

For health-care practitioners, the tradition of Buddhist wisdom can be an important companion as they engage with the suffering of their patients. Instead of denying suffering or treating it as a problem to be solved, Buddhist wisdom teaches that suffering is a grounding force that must be admitted and negotiated. Buddhists reinterpret the profound isolation experienced by those who suffer by explicitly recognizing the sheer fact that all humans suffer; suffering is common to all of humanity. Rather than being something that separates us from other people, it is, in fact, an experience that we all share. Curiosity, mindfulness, and radical acceptance of emotional

[351] Thich Nhất Hanh, *Peace Is Every Step: The Path of Mindfulness in Everyday Life* (New York, NY: Bantam, 1992), 26-27.

states are means that the tradition offers as ways of relating well to the inevitable suffering that is a part of being human.[352]

KING LEAR: THE BALM OF COMPASSIONATE PRESENCE

The Shakespearean play *King Lear* can also be a companion for those who suffer or want to understand how to engage those who are actively suffering. The gift offering within its pages is a sustained aesthetic encounter that, by demanding the reader's attention, helps him vicariously experience raw human suffering. The text, pregnant with meaning, can be read or viewed multiple times, and each time some new truth about the human experience can be revealed. It features characters both young and old. Some are villains, while others are simply victims of the misfortune of being imperfect and human. The play demonstrates that, through moral witness and love toward another, one can learn to bear suffering even after he has been plunged into boundless despair. The play offers a different kind of text to the student—one that can be read, but one that is also meant to be seen. A masterpiece like *King Lear* offers multiple sites of entrance for the viewer or reader. Different characters offer different points of entry as the suffering person or the caregiver.

In the third act, the old king—whose vicious older daughters have stripped him of dignity and any feelings of worth—stands exposed on a heath in the midst of a torrential downpour. Struggling desperately to maintain his sanity, Lear cries out to anyone who

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[352] For an excellent poetic representation of nursing as a form of mindfulness, please see Amy Marie Haddad's poem, "Dehiscence" in *Between the Heartbeats: Poetry and Prose by Nurses* ed. Cortney Davis and Judy Schaefer (Iowa City, IA: University of Iowa Press, 1995): 86.

would hear. He challenges the weather, taunting it to do its worst: "Blow winds, and crack your cheeks! Rage, blow! . . . Strike flat the thick rotundity o' th' world. / Crack nature's molds, all germens spill at once / That makes ingrateful man."[353] Lear does not gain power by railing against nature and the brutal elements but rather articulates and laments the chaos and misery he feels. Having lost his servants, the love of his children, and his dominion over Britain, Lear has nothing. With the weather mirroring Lear's turmoil, the audience witnesses Lear's utter ineffectualness, as well as the helplessness of those who surround him.

The Earl of Gloucester, in the subplot of the play, has also experienced tremendous loss. Though he is full of bravado at the beginning of the play, bragging about the conception of his illegitimate son, his foolishness does not warrant his later suffering. He has been made a pawn in the machinations of the bastard son, Edmund, who desires Gloucester's title and wants the old man dead. Edmund's scheming eventuates in Gloucester's turning against his other son, Edgar, who loves his father. Gloucester realizes the mistake, but only after having had his eyes poked out in a literal manifestation of his metaphorical blindness earlier in the play. Without eyes and without the love of his sons, Gloucester comes to the same desolate heath as Lear. In his sorrowful anguish, Gloucester says, "As flies to wanton boys are we to th' gods; / They kill us for their sport."[354] Gloucester conveys the unpredictability of life and the constant threat of misfortune.

In bringing Lear and Gloucester to the heath, Shakespeare gives the audience a specific site for thinking about the limits of human existence. He has stripped everything

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[353] Shakespeare, *King Lear*, 127.

[354] Ibid., 173.

away from both men, literally and figuratively. Even their clothing comes to be ripped or torn off; the two men are naked and forsaken. As Lear descends further into madness, he becomes more aware of brutality, fickle fortune, and human fragility. Upon talking to Edgar, disguised as a beggar and barely clothed, Lear grasps his own true, vulnerable nature. Though he addresses another, Lear describes himself, too, when he says, "Thou are the thing itself; unaccommodated man is no more but such a poor, bare, forked animal as thou art."[355] Edgar, disguised, sees Gloucester on the heath, piteous and wretched, and observes, "O gods, who is't can say 'I am the worst'? / I am worse than e'er I was. . . . And worse I may be yet. The worst is not / So long as we can say "This is the worst."'[356] No matter the chasm, when someone can articulate his misery in words, a lower place could emerge still.

King Lear can teach medical professionals lessons about humility and the boundaries that circumscribe human lives. The play can also be used to teach practitioners how we might be able to respond openly to the suffering that accompanies tremendous loss. At the beginning of the play, the egoistic and narcissistically absorbed Lear disowns his daughter, Cordelia, after she refuses to profess her love in an insincere and postured display of affection. Though Cordelia had once been his favorite daughter, Lear angrily banishes her without a dowry and without a chance at assuming leadership of any of Lear's land. In the midst of the further duplicity and suffering, the *idea* of Cordelia serves as a kind of compass throughout the play, reminding the audience of what is virtuous and true. Only after Lear has pushed right up to the edge of old age, madness, and death itself are he and Cordelia reunited. When the two come together, in

[355] Ibid., 139-140.

[356] Ibid., 173.

sorrow and forgiveness, Lear is able to let go of his needs and simply be with the daughter he loves so dearly. He imagines the two of them as caged birds, passing away the time by amusing themselves engaged in acts of idleness: prayer, laughter, telling and listening to stories. Cordelia cannot fix Lear's troubles; she can offer him nothing but companionship. Her attention, even after Lear has been boorish and unreasonable toward Cordelia, helps him to come back to himself. In letting go of the world, Lear is able to release some of his soul's burdens. Cordelia facilitates this for Lear by *leaning in* toward the reality of his misery. Her presence is a balm that opens up a space for a different kind of relationship with the suffering—one that is not afraid of the chaos, but rather enters into it, much like Job did with the whirlwind. In doing so, Cordelia takes on some of the burden felt by Lear, easing his emotional pain and providing true solace. Someone wanting to cultivate a compassionate presence can learn from Cordelia.

CONCLUSION

Borne out of medicine's functional similarities to religion, the eschatological narrative emerged in the late nineteenth and twentieth century with a powerful message. Having borrowed religion's features, such as its use of structural symbols and rituals, its hierarchical learning, and its access to numinous and awe-inspiring encounters with the human body, medicine adopted an eschatological narrative. Always on the horizon—never quite present but always drawing closer—the eschatological narrative's telos is elusive but seductive. The story believes that through human agency, disease and the experience of suffering will be rendered obsolete. In this hopeful, optimistic story, humans become their own saviors, creating the conditions for an overreliance upon physical redemption. Within this story, suffering must be conceptualized as a problem to be solved. Physical, social, and existential dimensions of suffering must be constrained or reconfigured to fit the finalizing demands of the narrative; the experiences of powerlessness and meaninglessness through time are interpreted as a physical problem to be treated or a psychological problem to be medicated.

Narrating a life in the shadow of the eschatological narrative limits the elder from articulating his or her fears, anxieties, and sources of grief and suffering because of the narrative's purported solution. The eschatological narrative imposes a response, but that response is constricted and cannot offer the narrative generosity that is inherent within the practices of narrative and literary gerontology. These methods, grounded in the tradition of the *studia humanitatis*, offer the practitioner multiple narrative ways of moving beyond the finalizing demands of the eschatological narrative. They promote a different

way of being with patients: one that is morally generous, connected, and creative. Though physical health might be unattainable, the health-care practitioner can still offer a morally rich presence that can tolerate the ambiguity inherent within the chaotic experience of suffering. Through this presence, suffering loses some of its sting; the feelings of powerlessness can be replaced with feelings of authentic compassion.

The practitioner who thinks with multiple stories is not bound to the demands of the eschatological narrative because he or she has many sources from which to draw. Unlike the eschatological narrative, which imposes a narrative closure upon those who embrace it, thinking with other narrative friends promotes a more expansive way of engaging with the suffering person. This kind of narrative competence teaches the practitioner how to be with someone whose story is incoherent. Instead of the forced narrative coherence placed on a person's story by the form of the eschatological narrative, this type of engagement recognizes the suffering elder's life story as an unfinished project—even towards the end of the person's days—and the practitioner places herself into a relational space with the patient that honors the potential of change, growth, and community.

The kind of narrative project for which I am advocating must begin in the early stages of medical and pre-medical education and continue as these students become practicing geriatricians. Just as true friendships develop slowly over time, so too must narrative competency, and the development of literary friendships grow as a student goes through the educational process. Stories such as the ones I have discussed are particularly well-suited because they contain an abundance of meaning. They are the stories that have lasted across hundreds of years, giving generation after generation new

opportunities for literary companionship. These are the best kinds of friends, ones that have accompanied myriads of readers who look to them for guidance and wisdom.

Within the practice of medicine, however, the stories that I discussed are neglected friends. The stories wait on the shelves, waiting to be welcomed into the clinic and hospital. By integrating texts like the ones I have discussed into pre-medical, medical, and graduate medical education, medical humanists can encourage young physicians to think mindfully about suffering, to be curious about patients' sources of suffering, and to be in the world in ways that, like Cordelia, open them to their patients' experiences of chaos and suffering.

This project ends with a beginning. In this dissertation I have introduced the eschatological narrative, outlined its historical development, and explored how the narrative affects the ways that elders suffer. The dissertation has described suffering's characteristics and presented narrative and literary gerontology as means for elders to resist the finalizing demands of the eschatological narrative. I have also engaged in the exegesis of three examples of literary texts that can be used to help health-care practitioners imagine other meanings and purposes for suffering.

As I end this project, however, I realize that I am on the precipice of a larger study. The eschatological narrative is an ingrained part of the social imaginary of American medicine and its effects are not easily minimized, much less relinquished. The easy response to suffering is to treat it as a problem to be solved—now or in the future—and not a mystery with which to reckon.

The work of this dissertation, which is only the first step, has been describing and revealing the eschatological narrative as an aspirational story that functions within the

broad culture of medicine to silence the articulation of chaos and misery, particularly among elders. The next step, which I have alluded to but not fully explicated, involves the further expansion of a vision of medicine beyond the eschatological narrative.

The generous acceptance of and deep response to a patient's particular story of suffering opens the practitioner to the possibility of having his or her own story transformed. By opening oneself to the vulnerability that is shared as one person suffers and another witnesses, both people open themselves to revising their respective stories. In doing so, practitioners can take seriously the notion of being a presence to the one who suffers. Though the other always remains a stranger, the practitioner can become a witness to their experience. In moving from a strategy of doing something to being-with, the practitioner can relinquish the fantasy of the eschatological narrative and can ultimately realize human and humane interaction, which is the foundational element of care.

I agree with Arthur Frank that the moral imposition lies with the practitioner to create a generous and open space that is wide and deep enough to contain the chaotic expressions of suffering. The suffering person, who enters the clinic or hospital vulnerable and in crisis, cannot be expected to be the one to initiate such existential conversations. If health, as I discussed in the prologue, involves more than simply the absence of physical disease, and if the goal of medicine is to maximize health, then practitioners are indeed charged with responding to these elements.

The next phase of this project is to further develop the architecture of such a generous moral space. The way to do this, I believe, is through an education that encourages the cultivation of the virtuous self. What I am advocating for is the

development of character traits that lead to morally capacious ways of being with those who suffer. These ways can hold within them the ambiguity and mystery of human suffering and can lead to surprising ways that suffering can be interpreted, understood, and tolerated.

The development of such character comes out of an ongoing relationship with teachers, and I have argued that certain texts are best equipped to be these teachers. Through reading and interacting with texts, students can come to develop relationships with texts that can be used to create the kind of narrative polyphony necessary for resisting the negative aspects of the eschatological narrative. Students who want to engage in medicine as a moral career need to be exposed to these texts early in their education. This does not involve a grafting of medical humanities education onto an already full schedule of science classes. Rather, the reading of these kinds of texts must begin with undergraduates, continue through medical school, and be revisited in graduate medical education. Reunions with these literary friends must occur regularly for the student to cultivate a deep relationship with them.

The practitioner who thinks narratively invites the elder to enter into a rich, ongoing conversation about the moral ends of medicine and, by extension, life itself. The invitation to be heard can itself serve as a way of counteracting the silencing, isolating characteristics of suffering, but even if the suffering patient is unable to transcend the silence in the moment of the encounter because of her existential or physical pain, the physician can offer a compassionate presence that demonstrates fidelity and steadiness. Recognizing the multiple possibilities for interpretation, the physician who thinks narratively can work with the suffering elder to shape a story together with the patient

that is life-affirming despite the reality of finitude. Though the eschatological narrative's horizon may never be reached, armed with narratives and generosity, the practitioner and elder can stare fearlessly into the *tremendum*.

APPENDIX A: GLOSSARY

Eschatology—Studies within religious traditions of "last things." This branch of study concerns itself with ultimate end beliefs: the end of life, the world, and time itself.

Eschatological narrative of medicine—A term, newly coined by me, meaning a loosely articulated cultural narrative within medicine regarding its own imagined end times. The eschatological narrative of medicine imagines a radical end to suffering born out of a mastery of the human body. Health would be maximized in such a way that suffering would be negated. Within this hopeful narrative, suffering becomes marginalized or unintelligible as the person's attention is directed toward the time when medical interventions are sophisticated enough to eliminate the experience of suffering.

Geriatrics—A branch of medicine concerned with the management of health and disease in persons over the age of sixty-five.

Gerontology—A multidisciplinary field concerned with the study of the life processes from middle to late age. Gerontology studies physical, mental, and social changes that occur as a result of aging.

Health humanities—A new area of critical inquiry existing alongside the medical humanities but more focused upon knowledge for its own sake rather than knowledge that is to be used in practice. The health humanities utilize the traditions and disciplines of the humanities to examine notions related to health and well-being.

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Humanistic gerontology—A subfield of gerontology that investigates cultural and moral questions of meaning as they relate to processes of aging.

Literature and medicine—A broad subfield within the medical and health humanities that joins together narrative and medical knowledge. Those who work within literature and medicine analyze and explore the relationship between literature and medicine and the ways that the two fields are mutually informed by the other. Areas of inquiry include images and representations of health, illness, and disability; cultural understandings and practices related to the body; and the interface between the body and the wider biomedical complex, as they are represented textually.

Medical humanities—An interdisciplinary field of study, emerging in the late 1960s, that utilizes the traditions and disciplines of the humanities (literature, art, philosophy, history, religious studies, law, and social theory) to investigate moral and pedagogical issues within medicine and biomedical science.

Narrative gerontology—A subfield of humanistic gerontology and/or literature and medicine that utilizes the methods of narrative studies to examine questions of identity, meaning making, and representation as they intersect with and are informed by the processes of aging and becoming old.

Narrative medicine—A focus or competency within the practice of medicine that recognizes the importance and centrality of stories within the clinical encounter. Through the cultivation of the skills of reading, paying attention to, and interpreting the particulars of a story, practitioners of narrative medicine work to resist more reductive methods of thinking.

Religion—A wide umbrella term describing culturally ordered and systematic beliefs in an ultimately ineffable other. Functional definitions of religion examine the psychological and social *uses* of religion. Substantive definitions of religion focus upon religion as something unique and peculiar in and of itself.

Spirituality—A personal experience of or confrontation with the ultimately ineffable otherness, in its many potential shapes and forms.

Theodicy—The study within religion and theology of the nature and purposes of evil in the world.

Tremendum—Erwin R. Goodenough's term meaning the part of humanity that persons can psychologically apprehend but can never know (such as that which lies beyond death); the uncontrollable and incomprehensible aspects of being.

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