

It's all about mercy

By Dr John Pilling and Bishop Michael Langrish

Reflections on issues raised in the wake of the coronavirus pandemic

As we, a doctor and a bishop, have reflected on our response to the coronavirus crisis we have become convinced that whatever we do and say must have mercy at its heart.

Mercy is the usual English translation of the Hebrew word *hesed* (or *Chesed*). But the term also has connotations of compassionate, empathetic, loving kindness, a steadfast staying alongside those who are in need.

In the Old Testament, especially, mercy typifies God, and God typifies mercy. Being drawn into the life of mercy includes hospitality to the lonely, visiting the sick, comforting the bereaved, raising the spirits of the depressed, helping people through crises in their lives, and making those at the margins feel part of the community.

The past months have seen an extraordinary outpouring of mercy and loving kindness by people of all backgrounds, professions, cultures and faiths. Through mercy we have seen community at its best. When the Covid crisis struck it was communities that reacted the fastest. Within a few days help was extensively mobilised to support the elderly and vulnerable. This has shown no sign of diminishing.

This same drive to show mercy to our fellow humans has also been evident in the selfless commitment of those in the caring professions. Many have shown extraordinary commitment: workers sleeping at work, isolating from their families for weeks in order to continue to work. They have put themselves at risk. Some have died because of their determination to be agents of help and compassion to others. Mercy comes at a cost. But mercy is steadfast and continues to look for the next opportunity to show itself in word and deed.

With the passing of the first 'peak' such opportunities will not be far away. Foodbanks have been hard-pressed to cope in the short term. As unemployment bites and small businesses go to the wall, as families face the loss of income, the support that they and other community enterprises such as Credit Unions will be needed even more.

Yet a full understanding of mercy has yet to be applied to other aspects of this crisis, most particularly the values and perspective we bring to issues of life and death.



Death and the elderly

One value is the assumption that length of life is all that matters, the longer we live the better, the more medical assistance used to that end the better for every person. There has been anger that many older people have died of Covid. Some 90 per cent of deaths have been among the over-60s, of whom 90 per cent have had underlying health conditions. Every death is a loss to family and friends who are bereaved.

The reality is that death comes to us all and as we grow older, and frailer, life expectancy diminishes. What matters most? The remaining quantity of life – a few more years, months, weeks? Or the quality – in terms of freedom from fear or pain, the ability to

take pleasure in our circumstances, being valued and surrounded by the love and support of family and friends?

As medicine has become more sophisticated and treatments more effective it has been assumed that if it can be treated it should be treated. For some years it has been evident that as people age they no longer die of heart attacks – because of coronary stenting, nor of strokes because of better blood pressure control and the use of statins, nor of infection. Only cancer, dementia and general decline are left as possible pathways to death.

The number ending their years in care homes or lingering with unpleasant treatments for cancer or waiting simply to die has increased steadily. Care homes provide excellent care for their

clients, but they are not home.

On average an old person will spend 26 months in a care home. The staff will do their best to help them be occupied and keep in touch with their families. However their life expectancy is by then limited. It may sound harsh to our 'sentimental' ear but along comes Covid and many succumb. That is where mercy comes in, provided their dying is managed well.

Which is more merciful? Where and how would the elderly prefer to die? In a care home or their own home with good end of life care? Or in a critical care unit, having been put into an induced coma with their vital organs failing, their last contact with someone in full PPE – maybe by this stage confused, frightened and alone? Surely the former is more merciful.

Dying with dignity

Until this is acknowledged, more elderly people will suffer undignified and unpleasant deaths. Older people need the discussion and information that allows them to realistically face these issues of the quality of their living and dying. Much inappropriate resuscitation is undertaken, sometimes because the patient has difficulty facing death, often

without a hopeful faith, but often because the clinician fears litigation if they do not attempt resuscitation.

Living Wills, the existence of a Lasting Power of Attorney and the signing of a DNAR can assist a dignified dying. Such honest conversation about the likely outcome of their illness and the treatment options may take place on admission to hospital. How much better if these matters had been faced in advance of a critical or terminal illness striking.

The *British Medical Journal* recently contained several articles to assist doctors to manage their Covid patients optimally. It is recognised that some will opt not to be put on a CPAP machine or a ventilator and then appropriate medication can be given to relieve their symptoms whilst they die, as comfortably as possible.

It has also been suggested that carers at home, without medical assistance, can be instructed to administer drugs to a similar end. This represents a substantial change in approach and practice.

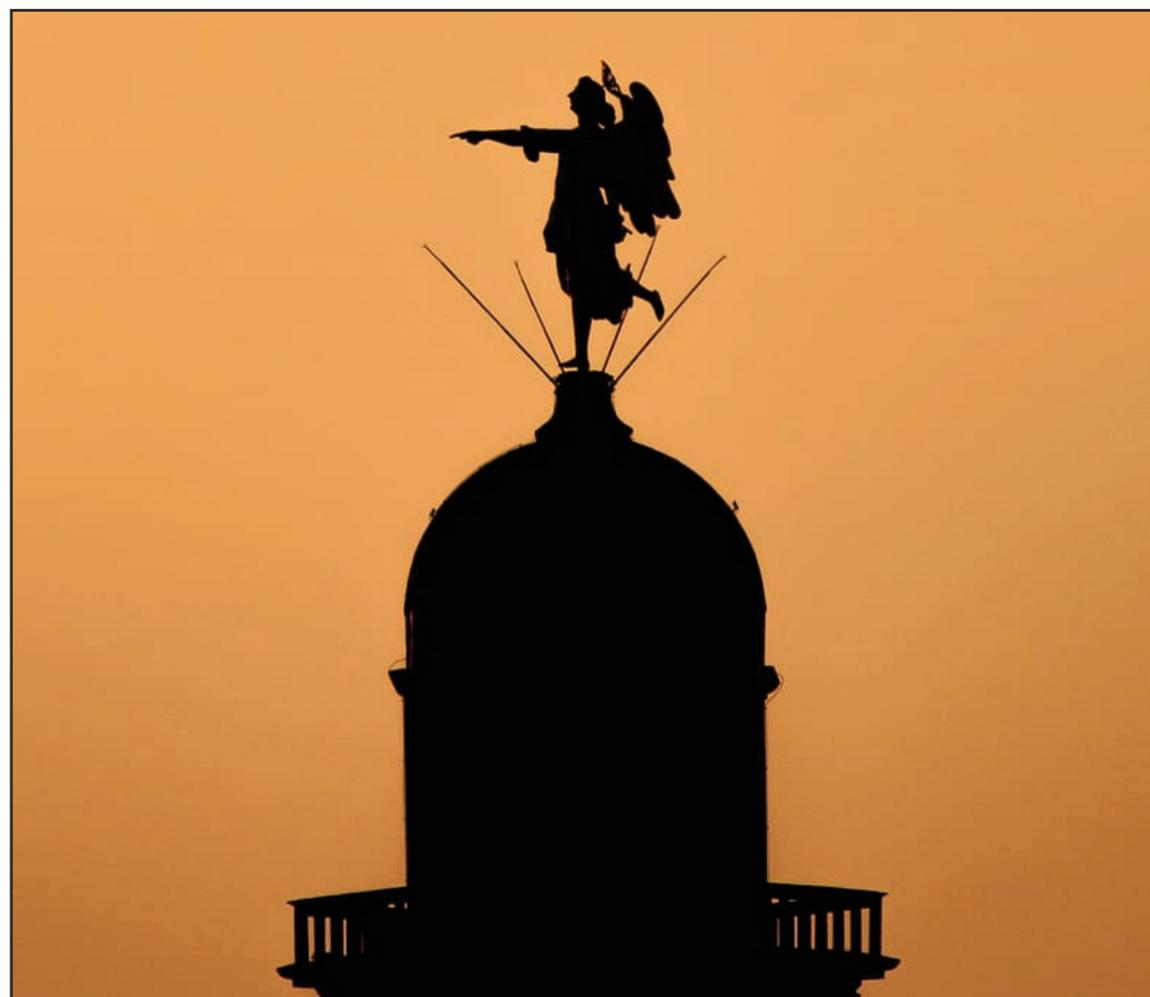
Managing Expectations

Such questions of practice are inevitably related to questions of expectation. Have medical innovations in the last few decades been used in the best way and to the best ends? Or have we simply drifted into a situation where the elderly suffer a lingering decline because treatments have been given without any thought except to prolong life at whatever cost?

Before antibiotics, doctors would commonly speak of bronchopneumonia, for example, as 'the old person's friend'. When declining physically, they would catch a cold, which would go to their chest, result in bronchopneumonia and they would gently slip away. It was a natural end, a 'merciful release'. Could this notion of a 'merciful release' inform aspects of how we are responding to Covid now?

Sadly for some the severity of their infection results in a distressing death requiring medical intervention to ease their dying. But might it be more merciful to ensure others could choose the place and mode of death and have only the treatment they need to make them comfortable?

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This in no way is to suggest that an older life has more value than a younger one, or that a life's expectancy and its value diminish at the same time. A selective approach to age that has been a feature of our failure to deliver joined up health and social care is a standing rebuke to our lack of mercy, while the loss of solidarity between the generations has negatively impacted our whole social fabric. One positive of this crisis may be to bring this issue to the fore.

A Quality of Mercy

The question we have found ourselves considering is about how a quality of mercy – of

compassionate empathetic loving kindness, a steadfast staying alongside those who are in need – could and should be brought to bear not only on the quantity of life for which we may strive, but as importantly the quality of that life and of its dying as well?

To that we as Christians, and more importantly the Gospel and the Easter story, have much to bring.

'I am the resurrection and the life,' says the Lord. 'Those who believe in me, even though they die, will live, and everyone who lives and believes in me will never die.' John 11: 25,26 – words spoken at the start of every funeral, but it has to be asked what the Church's official responses during these challenging times have shown

about how we understand them and take them to the heart of our lives.

In the Hope of Resurrection

Have we been guilty of failing to proclaim almost anything beyond a cosy belief in Jesus our friend who is always on our side? Christians are not protected from this virus. We are not promised immunity, we are just as likely to die as non-Christians. But we die in the hope of the resurrection, with experience of a perfect love that casts out fear, giving a peace that passes the understanding of many. To these things above all we as the Body of Christ are called to bear witness and share.

We do this in public pronouncements, not colluding with a culture of fear but modelling the freedom that comes from faith in Christ. It is our calling, in every aspect of our lives, to speak and act as people of mercy, showing a compassionate, empathetic, loving kindness and a steadfast staying alongside those who are in need. Such merciful actions may involve risk and cost – not least the cost of challenging some orthodoxies of our age.

We live in an age in which 'safety' has become a prominent, if not the most important, value in society. We assume life will continue into a long old age and death is something that happens eventually to old people.

Fear has gripped many of all ages, especially young adults, and is beginning to paralyse our thinking and reactions. It has been stoked by a media obsessed with tragedies who

focus unhelpfully on the dead and dying. It has gripped our churches as we have denied people access to places of prayer, close contact in spiritual and pastoral care, the consolation of the sacraments, together with that full funeral ministry and bereavement care that each soul deserves and all grieving families need.

Rather than give in to this zeitgeist is it time to change our perspective on life and on death and inject positivity and hope? But how will that happen and how does the Covid crisis bring this into the focus of mercy, hesed, rooted in God who is love.

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