Medicine of the Person. Hertenstein/Weggis (Switzerland) August 2006.

Motivation and the End of Life.

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The Book of Kings, in the Bible, refers to the life of the Kings of Israel. The stories always close with the same formula: “he lay down with his fathers and was buried”.

To lie down does not evoke the vocabulary of death. It evokes sleep. Five centuries later, when, Christ received the news of the death of the daughter of Jairus, he replied: “No, she is asleep; no she is asleep. (He also described the death of Lazarus as sleep). The text adds, as confirmation of the truth of the situation, He was mocked!

Thus from distant times, death is seen as sleep, a sort of refreshing lack of consciousness which, in spite of appearance, remains temporary.

If there is sleep, there is reawakening.
Did not speaking of death as a period of sleep spring from a deeply human intuition? Suppose human life does not end in physical death. Suppose also that its end were a process leading to a further experience of life.

I shall speak, from the basis of this intuition, of my motivation as a carer. I also speak about the motivation of the people, approaching the end of life, for whom I care. I start from an individual experience, and a very limited experience, that of a monastic nurse.

Meeting people who are aware of being at the end of life, reveals very quickly to what extent two realities are present: the fear of death and a strong desire to live, even in the case of those who wish “to put an end to it”.

All of us share the same fears, the fear of the act of dying, the fear of experiencing yet greater suffering, and of abandonment in the last moments, the fear of the great unknown, what happens after death. Fear of this kind belongs to my very essence, the real me (the I) that no one else can share.

It is curious to notice that the first use of the pronoun, I, spoken by a man in the Bible, is found in Genesis. God seeks Adam and Adam says to him: “I was afraid for I was naked and I hid myself”.

The first human “I” expressed in the Bible is related to fear. Adam’s fear is linked to his fragility, to his vulnerability for which the biblical symbol is nakedness. But his fear is based, first and foremost, on his ignorance of the possible reactions of God, of a God who remains, for him, the unknown One. Encounter with the unknown One always arouses fear and anxiety. This is particularly the case when the confrontation is inevitable. No one, in the case of death, can come to my aid from knowledge, or through personal experience.

The Christian mysteries do not only provide support in the war that stands in opposition to peace, but also in the case of fear itself. Fear is the source of so many

decisions and attitudes that distort or destroy human relationships. Fear can also be the cause of my own destruction.

As one accompanies a patient at the end of life, three areas of motivation appear to me of first importance.
Lead him along the path of peace.
Arouse in him a realistic estimation of the past.
Prmit him to remain in the flow of life.

Why of first importance? Because these motivations cover the present, the past and the future of the person for whom we are caring. They are indeed as necessary for the carer as for the one cared for.
How can one **lead . . . arouse . . . permit** . . .
unless one has begun to make one's own these areas of motivation in the management of one's personal existence?

LEADING THE PATIENT ALONG THE PATH OF PEACE.

To try and lead a patient along the path of peace means helping him to overcome his fear, or his fears, or, at least, helping him to live with them. I am his companion, as I too experience various fears.

This companionship can amount to a simple presence. It is curious to notice how the simple fact of being there . . . at his side silently . . . can sometimes enable the patient to feel secure. It can enable him to experience a kind of reassurance. Finally, it can offer him the best possible gift: to allow him to become more a person, to make more humane the last moments of his life, or of his lucidity.

Is it not a principal motivation of every carer to make more personal the last days, or the last hours, of seriously ill patients? . . .
"I am at peace because I know that He is alive!" These words spoken by a brother, 88 years old, with a tracheotomy, a few hours before he died, can be taken as the result of suggestion, illusions upheld by a strong imagination cut off from reality.

They can also be accepted as the expression of an authentic spiritual experience that belongs to another kind of reality, the reality of relationship. The texts of the great religions, like the findings of the human sciences, speak of man as a being made for relationship. This brother, moreover, has been a monk in a double relationship through his work as a spiritual listener for very many years and then by the functional responsibilies in the monastery that he undertook, in his previous position, in charge of arts and crafts.

What struck me about these words was the relationship that he placed, on one hand, between this inner peace that he was visibly living when his health was declining, and when he was suffering, and, on the other hand, the awareness of the strong presence of someone, indeed of someone real and alive, but invisible to my eyes. He was fully lucid as he left us on Christmas Eve listening to the broadcast of the chants of the community. This was a very powerful experience.

Peace and presence . . . the presence of someone . . .who by the fact that he is there, shares with me something most precious . . . himself!

This recalls for me a memory during night training in the hospital, twenty years ago. When someone was dying in a room, there was a rush out of the way! One night when I was no longer on duty, I was amazed at this surprising reaction. The reply rang clearly and distinctly: we are not there to hold the hand.

November 1999. Brother L, who is 87, is taken to hospital, as an emergency. He is a man firm in prayer, silent, and a lone worker, affable in contact and very human with his brothers. I remain silent beside him. He says to me, “Don’t stay any longer, I am at peace. I am going to die. I have little time left. Leave me”. With his hand, he gives me a sign to leave. He wishes to remain alone. His face reflects a great peace . . . I heard of his death when I returned.

Is not the search for peace an essential motivation in our life as a person? Peace in relationship to oneself from which springs peace in relationship to other people, peace so fragile in its essence, that it requires a persevering work to bring it into experience . . . Peace, the emblem of the monks of the West since the sixth century and so often handled roughly by them.

“Happy are the peacemakers”, says the Gospel.
Should not this sentence also concern those who, by trade and, let us hope, also by vocation, have chosen to be carers?

One might ask about the place given in medical education to a study of the relationship with patients and of the psychological effect of continual encounter with people who are suffering, complaining or aggressive.

Happy are the peacemakers in the medical profession who have known instinctively how to find the right words, or attitudes, in the presence of people who are coming to the end of life in a hospital room.

Happy are these doctors and nurses. They are the witnesses of a great and genuine humanity.

Peace at the end of life may also take on characteristics that are sometimes disturbing. Brother J.M., a professor of philosophy, was much influenced by his time in our monastery in Cambodia. Aged 78, and worn out, he began to fast during a stay in the infirmary. He claimed that his food ought to be in proportion to his bedridden status. He is declining, asking for the minimum of care. One day, he was offered prayer, in the presence of the community, for seriously ill people. His refusal was categorical. “I am not ill. I am simply going to die, as everybody does.” Nothing made any difference. He repeats: “as I have told you, I’m going to die!” In the evening, he sleeps; his pulse is regular. Everything is fine. At dawn, I go and see him. He was sleeping . . . In fact; he was dead, just like a sage from the East. What a lesson!

HELPING THE PATIENT TO AN APPRCIATION OF THE PAST.

As the end of life approaches, the patient regularly returns to his past. Intending to be true to himself, he often casts over it a negative view, not lacking in guilt. He can become the victim of a failure syndrome. He faces the temptation to flight in the face of a reality, painfully experienced because insufficiently verbalized or shared. The danger is that he will build a defence by flying into imagination, and turn himself into the most misunderstood person, persecuted by everybody.

“During the war in Vietnam, I had to take decisions for which I was reproached. In Africa, I came across cultures that I wanted to show to advantage. In fact, I was not understood. I was never listened to. That has been the case throughout my life and now, I stand before my conscience, and soon before God.”

The carer can play an essential role in a case like this. He has to facilitate the integration of a past. This past is burdened with misunderstandings, inevitable errors, and false flights. It is weighed down with things badly accomplished, sometimes voluntarily, at other times, involuntary. But there is also a past, marked by successes, hours well lived, and happy memories that we are going to leave behind us.

The last point is perhaps very sensitive. It touches on the image of the patient. This is the image that we all need to keep positive. It demands from the carer, perseverance. And if, little by little, the picture of himself begins to be seen positively by the patient then he experiences an enormous liberation through relief, the removal of guilt feelings and other burdens. Things like these bring an enormous liberation. There is a striking increase in the quality of life.

A brother, aged 81, comes into the infirmary in the final phase of a prostate cancer. He makes known his concerns and straight away says to me with gravity. “I haven’t got long left. You are going to take care of me, to accompany me. From childhood, my father treated me as an imbecile, an entertaining spectacle. I want you to know this.”

What intimate suffering was revealed by these words, offered as a gateway, into our new relationship.

It is in the light of suffering, regrets and expressed anxiety, that the carer can encourage, in the present moment, a fairer evaluation of the past. He can do this through a receptive attitude, a tangible attention, an empathetic ear, sometimes by a word that speaks of peace,

To take a straight look at the patient’s life is neither to approve nor to condemn, but to look at a truth that it is often difficult to see on one’s own.

The carer has no forced access to the past history of the patient. He has only the opportunity to listen from the heart. He listens profoundly to a person sometimes tragically aware that his death is at hand. This can give the patient access to a true reconciliation with himself. It is an indispensable path along which to enter into that inner peace, a peace that makes possible acceptance of the inevitable.

A constantly recurring situation is to go over events from the past and ask, Why has such a thing happened to me? Why am I involved in it? Why did I do that? At the end of life it is indeed late to find a right answer.

The Bible provides one.

When God forbids something, Adam remains silent before the test. (Let us not forget that this is a myth, a symbolic story). But the serpent suggests: Why does God forbid the trees of the garden? This “why” intends to lead Adam on a false trail, for Adam and Eve have no access to God’s true reasons. They are not God.

The Gospel likewise opens with a test that is the counterpart of Genesis. God imposes on Mary, not something forbidden, but an impossible mission.

Mary is afraid. What response will she make? An agonized questioning of the type: Why me? Why are you making me do that? Or, as an echo of the serpent: Why does God ask such a thing of me?

In place of this attitude, that anybody would have had, her response, in the face of the test, is remarkable for intelligence and wisdom.

The why is replaced by how? “How will that happen to me?”

Many “why” questions remain unanswerable. This is the case in the huge tests that befall us, and especially in situations at the end of life. These questions are directed towards a past where causes escape us, a past to which we no longer have access, a past that remains silent.

By contrast the “how” questions reveal a completely different dynamic. They first take in hand the real situation and the present sufferings. They seek the best method to take them on board now, today. This amounts to a change in the nature of the question. It represents a movement from seeking to rediscover causes from the past that cannot be found, to the difficult management of the present. It can lead the patient to depolarise from the weight of his past and experience a measure of relief. This is a fact of experience.

It may be that this past is a burden heavy to bear; perhaps a derailing youthful error, that returns to the surface. This happened to a brother, originally from Morvan. He prided himself in finishing the war in the S.S. during the battle for Berlin! His need was for reconciliation with himself. This meant coming to terms with his personal story. He sought to justify his bravery and motivation. In his last days, he was liberated from a past that had weighed on him for 48 years. This, he achieved, by opening himself through a total abandonment to Him whom he knew that he must meet. But this abandonment, and the peace that followed, were alone possible, thanks to the patient and the prolonged listening of several brothers. The brothers followed one another at his bedside to assuage an anxiety heavily guilt laden.

Reconciliation with the past may also involve forgiveness for the people regarded as responsible for suffering experienced in times gone by. This may be the case among

brothers who have known abandonment in childhood and placement in an adopted family before they became monks.

There are people who have been the victims of a too demanding, or of a dominating or stifling, mother. A “gospel” pardon is almost always given in the course of life to the people responsible for one’s suffering. But the last moments of existence can experience a revolt of extreme violence, something that can make the carer the object of open condemnation. Forgiveness involves changing sides! It is the turn of the patient to receive forgiveness. The carer has now to think carefully about his motivation as it risks damage from the violence pitted against it. The carer is well aware that he is a symbolic object. We must not forget that in a monastery the two partners in this final storm live in the same places night and day.

Peace generally appears and motivation is still present, thanks to the help of the brothers, to the support of the Superior, and to the carer’s appreciation of the situation.

This shows how support at the end of life requires a circle, a support group, so that the different situations can be managed in the best way possible for both the carer and for the patient, who on his bed of suffering, is the only person who knows with what he is wrestling.

The problem of a realistic estimate of the past is an abiding feature. It is essential to arrive at what we all desire, the principal motivation of our existence: to become ourselves, not to die without having discovered who I am and lived out the person that I am!

To become ourselves is a primordial wish for us, for we are always failing to achieve. We are ever at work, always unsatisfied. We pass through time, open to constantly occurring new experiences. Ceaselessly, we seek personal fulfilment that the happy times of our life allow us to anticipate.

Motivation to become ourselves presumes long and patient work. The task is regularly hindered, or set back, by wounds that are often deep, difficult, and sometimes impossible, to take in hand.

Becoming ourselves takes for granted an estimate of the past that puts in their true light blissful experiences, all life’s happy moments. These lively memories make possible a less burdensome monitoring of the patients in our care. It is often the obscure, or sombre, areas in our past that dominate the field of conscience. They reveal themselves in our conversation, as also in our attitudes. By thinking about the happy moments, we are able to offer, in spite of the difficult experience of every day, a comforting attitude to a person who expects so much from us
Carers obliged to provide a service, often reveal sombre, if tragic faces, or stressed attitudes. I can never forget a memory when I was covered with pipes during resuscitation. The nurse, silent and face withdrawn, and without a glance, washed me in freezing, really freezing, water. . . Those who followed were entitled to better treatment. They had warm water!

The happy experiences of the past, and our personal struggle against the weight of the present, allow us to see the patient in his true light. They also enable us to be interested in the unknown experience through which he is living.

What a mystery behind the two eyes that look at us and await something from us!
What a mystery behind the two ears that listen to us with more or less difficulty.
What a mystery behind the eyes, outstretched towards the person who is approaching, waiting intently for good news, a word that brings a glimmer of hope.

A brother has been in the infirmary for nine years. He is a former professor of theology and philosophy. Afterwards, he founded our photographic laboratory for Roman art. He has been completely paralysed for three years, deaf, almost blind. He spoke to us by a glance and thanked us with an extraordinary smile. He followed all that we were doing, and, now and again, uttered a word always tinged with irony. A short time before his death, he spoke loudly a word, “Nincompoop”. This was the name he used for me 40 years earlier when I was his pupil ”Nincompoop!” was a very kind and affectionate designation in his mouth. Composed of malicious irony, and revealing, at the same time, a complete absence of fear and anxiety, this was the last word from a monk totally given to God and to his brothers for 56 years.

Someone once said: “When we have been listening for a long time and when we have shared for a long time, the other person becomes a permanent source of inspiration”. We could say, in the same way, that the other person becomes a source of permanent motivation. I can never forget the brother, so handicapped, who taught us by his simple presence.

He compelled us, he constrained us, to live differently . . . our word . . . our time . . . our body . . . our normal points of reference . . . our way of life.
Thank you, Daniel.

Individualism is a major characteristic of western society. Individualism can have unfortunate consequences for the carer and distort his most generous sense of motivation. Individualism throws his roots into a gradual process of separation from the main areas of human activity and so gives to the individual an importance previously unknown.

And so, in the face of a barrage, defences, carefully supported by our need for autonomy, can suddenly appear. Illness, severe depression, loss of strength, really do plunge us into the situation so much feared, dependence on other people.

This situation is indeed present among those for whom we care in the evening of life.

Are they not the carriers of a word about knowing how to welcome? Do they not also invite us to lead them along a path of peace? We are the first to benefit by accepting the messages that, unwittingly, they signal to us. From them we can draw strength and wisdom for the future.

HELPING THE PATIENT TO REMAIN IN THE CURRENT OF LIFE.

A person at the end of life faces a unique experience that he cannot communicate. By day or by night, pain may become entirely pervasive and sweep through his whole being.

"I face a suffering body, hardly anything else. Everything is a problem for me. I find it impossible to pray, to communicate, I live in a continual fear that that thing conceals." (Patient of 88 with a tracheotomy).

To allow the patient to remain in the current of life is it not necessary to assure him of a presence? A very careful listening is required, a listening that hears his anxieties, his feeling of helplessness, his moral, even spiritual, suffering.

He knows, he feels your presence, even if no conversation seems possible. The difficult art of listening brings to birth a feeling of being understood. Listening breaks open the extreme loneliness of the patient. It comforts his feeling of isolation. It arouses an awareness of still belonging to the world of people who are living actively. He remains a being in relationship.

It is extraordinary to discover the extent to which listening is a major humanizing factor for a person who suffers. The feeling of abandonment and neglect can pull one apart. I think of the friend who said to me, "Since the diagnosis of my incurable condition dropped, I no longer see a large world of medical staff. I feel tragically alone, abandoned . . . I await death".

Solitude, abandonment, death go together.

Presence, listening, word, mean **life, relationship, humanisation**.

The Bible, this expert on humanity, tells us, "God created man in his image, man and woman, he created them". It draws attention forcefully, not only to the fact that a human being is designed for relationship and sharing, but that he is in essence a being in relation:
With Nature that he has to govern and control:
With his fellow beings whom he encounters in order to live in mutual aid, an aid that takes difference into account:
With God, whose image and likeness he bears; he is a full participant in the divine transcendence that will lead him to the fulfilment of his complete life as a person.
Man is the only part of creation to have this three dimensional capacity.

It is he alone whose life is a long path of human and spiritual apprenticeship, all the way to the evening of his existence. This means that the presence and the quality of relationships, that ought to crown the last moments of life, are of first importance.
I have been a powerless witness of hospital carers who abandon to solitude the fully conscious dying patient. A situation like this smashes a human need, sometimes intense, and ignores silent and unexpressed appeals for help. It is an extremely unnatural attitude, causing the patient to die prematurely, before "his" time.

Simply to be there, to maintain a real, if silent presence, is to bring to life what remains to the patient of rational, often auditory, perception. It means taking part in

his situation as a person that will be fulfilled in the quite different life that is to come. We have a premise about this life without knowing what it will be like.

To allow the patient to remain in a current of life means, in the end, following the state of his mental faculties. It involves seeking to nourish in this person, worn down by the illness or by the loss of physical strength, a treasure that one may describe as a spiritual longing.

Spiritual does not mean immaterial, discarnate, imaginary, but points to something at the heart of our very selves. It makes us capable of transcendence, of universality, and liberation from all the lack of clarity that life accumulates. This very delicate support depends entirely on the potential of the carer and on his personal horizons. The support can sometimes preserve unforgettable traces of beautiful words heard, of the desires, and even of the intimate, joys expressed. Experiences like these can nourish and strengthen the carer's sense of motivation.

This kind of support may require more than the available strength. The behaviour of the patient, the physical, and especially the psychological degradation, can become unendurable. In a monastery, one is caring for a brother, a brother with whom one has shared a long experience. Such experience may have involved disagreements or a clash of temperament. In the case of this patient, one is obliged to follow a highly intimate path. The motivation of the carer can then be in for a severe test. He is compelled to begin to question himself, to recognize his weaknesses, to discover his fears. The violence of patients can go as far as providing an opportunity for the carer to come to terms with any failure of his own that comes to light.

The support of brothers at the end of life in a monastic community is, to some extent, the responsibility of everybody. There is a considerable degree of freedom within this responsibility. Some members like to visit the seriously ill, speak to them, pray with them, and offer them a small last gesture or come simply to hold the hand in silence. Some are fascinated by death and choose to be there to offer help in the last moments. Others flee from these encounters. They are capable of acknowledging their very real fear.

What may be the motivation of these different brothers? For the most part, motivation involves compassion, emotion, when a companion of the same generation is involved, even training or study, or the quite simple desire to give fraternal assistance.

I believe that I can say very sincerely that fraternal love guides these men of every age who come to the bedside of their brothers. The difficulty is great when brothers are in hospital. Withdrawal gives a particular character to these visits, as does the environment in a hospital ward. Television, families who spend a long time by the bedside of a neighbour, or who speak loudly, and noises, from the corridor, are terrible intrusions for a person who has lived in habitual silence.

The carer faces a frightful problem. Should one tell the truth to a brother who asks, even when no doctor has dared or wished to approach the subject? What is the best approach to help him to live with, or to live better with, what is coming to him, and of which he would like to know the definite outcome?

Two questions arise for consideration.

Is it desirable to leave him enmeshed in a collection of lies, false evasions or simply evasive responses? The difficulty is that the patient feels a lack of ease and of discomfort on the part of the person to whom a question is posed. His anxiety increases if he notices people whispering at his bedside, or looking at him in a questioning manner. Some quickly guess, others ask, and await a uniquely calming response.

Is it desirable to establish the truth as a matter of principle when only a direct encounter with the truth can enable the patient to respond and adapt to his future?

One brother, of our community, who was a doctor, originally held this view. But, then, how can we foresee the reaction of someone whom we know only slightly? Each patient is a unique human being, made so by personal history, previous experiences and by family or national culture.

A gravely ill African monk expressed, in spite of his western monastic formation, his pain and his anxiety in a manner totally strange to us. It was beyond comprehension. When aware of the nature of his illness, he rolled on the ground half naked, howling. He did so in the very middle of the hospital corridor and repeated the same thing in our house. I learned afterwards that it was a local custom for expressing extreme distress and an appeal for help to which the neighbours would rush! Mutual aid in the village was expressed like this.

But what does one do in Europe? How do we welcome and understand this behaviour?

The truth, I believe, is not an end in itself. To unload it on somebody, as I saw done by a hospital doctor in the case of an 82-year-old brother who was not expecting it, (“Do you not indeed know that you have a systemic cancer?”) was an unheard of act of violence of which the perpetrator was completely unaware.

The ideal is to make of the truth a path of fellowship with the patient along which one travels with him. The purpose is to help him to think about the future that causes him distress.

The ideal is to enable him to discover, and express, the truth that he already realizes, and the truth that he is squeezing out of mind. He may well need to become consciously aware of this truth in order to live out fully his remaining time.

This is an ideal . . .

What have I received from my brothers in the evening of life?
More than different ideas about motivation, they have left to me an **Art of Living**.

Respect for the other in his originality that is so disconcerting.

Keep an appropriate distance from him to limit the mechanisms of projection and identification. The other person can never be me, but he remains an actor in my life.

Realize that one does not understand everything, about the other person and about oneself. Accept failure, and that some things will be open to question.

Be prepared for a double experience: the end of life, the passing into the unfamiliar of the other person. The time before a death can be rich in meaning. If death has no impact on our lifestyle, we impoverish our lives by taking leave of reality. Contemporary society believes that by avoiding death, and the accompanying rituals, intended to civilize it, one enjoys a better life.

Seek and strive for interior peace, (quoted from the rule of St. Bernard) by remembering what all my departed brothers have taught me in a powerful manner. The fruit of personal existence is found less in “doing” than in “being”.

I would like to close by saying that the art of living is quite simply **an art of loving**.

Thank you for your attention.