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The Order of Widows: What the Early Church Can Teach Us about Older Women and Health Care

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This article argues that the early Christian "order of widows" provides a fruitful model for Christian ethicists struggling to address the medical and social problems of elderly women today. After outlining the precarious state of the "almanah" - or widow - in biblical times, it describes the emergence of the order of widows in the early Church. Turning to the contemporary situation, it argues that demographics both in the United States and around the globe suggest that meeting the needs of elderly women will become an enormous challenge in the years to come. The order of widows illustrates a three-fold conception of solidarity that has immediate implications today. That conception of solidarity encourages us: 1) to identify the unique medical needs of elderly women (e.g., osteoporosis); 2) to find ways of overcoming their societal isolation, which can increase their risk of medical and psychological problems; and 3) to develop strategies for enabling them to remain contributing members of the community for as long as possible.

Keywords: *early Christianity, health care, older women, Order of Widows, solidarity*

This essay is a slightly revised version of a keynote address given by the author at a conference on "Women's Health and Human Rights" held in Rome, Italy in February 1998 and sponsored by the Vatican, Georgetown University, and the Università Cattolica del Sacro Cuore. The proceedings of that conference were published in Italy by the Società Editrice Universo-Roma in a volume entitled *Women's Health Issues*, edited by Spagnolo and Gambino (2003).

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I. INTRODUCTION

> Meanwhile, standing near the cross of Jesus were his mother, and his mother's sister, Mary the wife of Clopas, and Mary Magdalene. When Jesus saw his mother and the disciple whom he loved standing beside her, he said to his mother, "Woman, here is your son." Then he said to the disciple, "Here is your mother." And from that hour the disciple took her into his own home. After this, when Jesus knew that all was now finished, he said (in order to fulfill the scripture), "I am thirsty." A jar full of sour wine was standing there. So they put a sponge full of the wine on a branch of hyssop and held it to his mouth. When Jesus had received the wine, he said, "It is finished." Then he bowed his head and gave up his spirit. (John 19:25–30)[1]

To a casual observer watching this scene from the Gospel of John on a dark Friday afternoon two thousand years ago, the mother of Jesus would have appeared to be a figure whose social and familial position placed her at grave risk of a desolate future. She was not a wealthy or well-born woman. Relatively speaking, she was an old woman, probably in her late forties in an era when fewer than four out of one hundred women lived past the age of fifty (see P. Brown, 1988, p. 6). Most devastating of all, she was very likely an *almanah* — a widow. Moreover, she was an *almanah* whose only child and only son had just been branded a criminal and condemned to death at the hands of Roman authorities.

In this essay, I will suggest that Christian bioethicists would do well to consider the situation of the *almanah* in biblical times as a fruitful source for reflection about an emerging crisis facing our health care financing and delivery system: the enormous increase in the number of elderly Americans demanding medical and social attention as the "baby boomer" population grows older. Statistics suggest that the vast majority of the elderly population will be women, many of whom will outlive their husbands. The particular vulnerability of this segment of the population has not lessened significantly over the ages; the precarious situation of the widow in biblical times provides a vivid background against which to understand the plight of many elderly women today.

Moreover, I will suggest that the solidarity with elderly women expressed by the early Church in its creation and maintenance of an Order of Widows provides helpful clues for how to respond to the situation of elderly women in our own era. Christians ought not approach bioethical questions as if they were narrowly technical or academic matters; these questions must be situated within a broader concern for the flourishing of human persons as made in the image and likeness of God. I suggest that properly understood, solidarity with elderly women requires us not merely to meet their sorely underserved medical needs, but also their need for

human companionship, and even their desire to continue to contribute to the communities to which they belong. These issues are deeply interconnected. For example, the failure of the medical community to pay sufficient attention to osteoporosis has resulted in some women losing all mobility and independence. Loss of independence and isolation can be a contributing factor to depression, which in turn can increase a patient's risk for suicidal ideation. As Eric Cassell (1991) has eloquently documented, the suffering associated with serious medical problems calls into question the integrity of a patient's whole identity. Consequently, Christian bioethicists must approach the medical-moral problems associated with aging women in an appropriately holistic way.

II. THE *ALMANAH* IN BIBLICAL TIMES

At the root of the Hebrew word for widow, *almanah,* is the word *alem*, which means "unable to speak" (Thurston, 1989, p. 9). In the social framework of biblical Judaism, as in many other Near Eastern societies of that time, women could not speak for themselves; they were dependent upon the care and protection of male relatives who had legal authority to speak on their behalf. An adult woman's social status and security was determined by her roles as wife, mother, and mistress of the household; her husband was responsible for supporting her and representing her in all matters of public concern. Consequently, the death of a husband meant not only personal grief, but also radical social upheaval and economic uncertainty. As the newly widowed Naomi's lament to her mother-in-law Ruth demonstrates, it was a fate most feared and bemoaned by women.[2]

In the patriarchal, patrilineal world of the ancient Near East, a woman whose husband died was still considered to be part of her husband's family. After her husband's death, her support became the obligation of her sons. If she was of childbearing age and had no sons, her father-in-law was expected to arrange a levirate marriage for her. A woman who has lost her husband, who cannot remarry, and who has no sons to provide for her care, is in a precarious position. Precisely because she is devoid of a male relation to speak on her behalf, she is truly *alem*— unable to speak, unable to provide for and protect herself. On this basis, biblical scholars have argued that by itself, the English word "widow" is not an accurate rendering of the Hebrew noun *almanah*; a better translation is a "once-married woman who has no means of support."[3]

An *almanah* was deprived of support in two crucial respects. First, she was economically deprived; sometimes she was forced into slavery or prostitution in order to obtain sufficient resources with which to live. Second, she was socially ostracized, frequently pushed to the very edges of the kinship structures governing her existence. Widows were so frequently subject

to abuse that the Book of Job used their exploitation to exemplify human iniquity. Other passages from the Old Testament apply the term *almanah* to cities such as Babylon and Jerusalem to depict their desolation and isolation from God (Holwerda, 1988, pp. 1060–61).

Although frequently ignored by the wealthy and powerful, biblical law attempted to provide the *almanah* with minimal protection. The Old Testament prophets tirelessly railed against widespread oppression of the widow (1 Is. 1:17, 23; 10:2, Jer. 7:6; 22:3, Ezk. 22:7). The cloak of a widow was not to be taken in pledge (Dt. 24:17); along with orphans and strangers, she is to receive a share of the tithe collected every third year (Dt.14:29; 26:12–13) and has a claim on the fruits and grain that fall to the ground during harvest time.[4] In Israel, like other ancient Near Eastern societies, it was the special responsibility of the king to safeguard widows and other vulnerable groups. Nonetheless, because the human heart persistently hardens itself against God's commands, the ultimate hope for the *almanah* is the Lord. He alone will meet her material needs and erase the scourge of her ostracization.

Witnessing the execution of her only son on that dark Friday afternoon, the mother of Jesus stands in solidarity with the most vulnerable women in her society, for she is about to become an *almanah*. How should we interpret the Johanine passage in light of our understanding of biblical widowhood? On a literal level, the text clearly recounts how Jesus provides for his mother's care after his death by commending Mary and John to each other as mother and son. But there is a deeper symbolic meaning as well. John's Gospel, after all, was written not in the shadows of Good Friday, but in the light of Easter Sunday, which had already revealed Christ's divinity to the Gospel's author and his early audience. Consequently, the author of the Gospel discerns in the details of Christ's earthly life a pattern of symbolic meaning that reaches back in time to fulfill Yahweh's promises to Israel, and points forward to herald the sacramental life of the Church (R. Brown, 1982, pp. 11–13).[5]

Viewed in this light, Christ's commendation of Mary and the beloved disciple to each other is the fulfillment of the biblical widow's hope in Yahweh for deliverance and vindication. Just as the cross, a sign of shame and death, becomes transformed in Christ into a symbol of divine glory and eternal life, so in Christ's mother widowhood becomes reconstituted from a sign of weakness and isolation into a symbol of strength and inclusion. The central place of Mary in the ongoing life of the Church furnishes a vivid expression of this reconstitution. For example, later representations of the Pentecost show Mary seated in the middle of the Apostles with the flame of the Holy Spirit descending on her head along with theirs. Similarly, the Byzantine image of the crucifixion found in the Deesis icon portrays Mary on the left of the cross and John on the right, representing the Church in supplication to Jesus.

Christian theologians have frequently traced the birth of the Church to Christ's crucifixion and death, recognizing its two great sacraments of baptism

and the Eucharist in the water and blood that flowed from his side.[6] At the foot of her son's cross,[7] Mary "stands at the very center. "of the Paschal Mystery of salvation (John Paul II, 1987, ¶ 23). In his encyclical letter, *Redemptoris Mater* (1987, ¶ 45, emphasis in original), Pope John Paul II writes:

> The Redeemer entrusts his mother to the disciple, and at the same time he gives her to him as his mother. Mary's motherhood, which becomes man's inheritance, is a gift: *a gift which Christ himself makes* personally to every individual. The Redeemer entrusts Mary to John because he entrusts John to Mary. At the foot of the Cross there begins that special *entrusting of humanity to the Mother of Christ*, which in the history of the Church has been practiced and expressed in different ways.

We can see a two-fold movement toward community in this passage from the Gospel of John, rooted in Jesus' parallel commissions to his mother and to the beloved disciple, and reaching across time into eternity. John integrates Mary into his kinship structure, thereby saving her from the social isolation suffered by an *almanah* in that time and place. At the same time, Mary, the *almanah*, invites John, and with him all humanity, into eternal kinship with her son, the Christ who has saved us all from the deeper isolation of sin and death.[8]

Furthermore, as the Church constituted around the Gospel has long recognized, Mary does not sit passively at the center of the redeemed community, she takes an active role in nurturing it. *Lumen Gentium*, the Second Vatican Council's Dogmatic Constitution on the Church, emphasizes Mary's ongoing activity on behalf of all humanity (Vatican II, 1964, ¶ 62).[9] On this basis, it reaffirms the use of the traditional Marian titles of "Advocate, Auxiliatrix, Adjutrix, and Mediatrix," while emphasizing that they neither take away from nor add to the dignity and efficacy of Christ as the one Mediator (Vatican II, 1964, ¶62). In these titles, we see the ultimate vindication of the *almanah*, the one "unable to speak." In Mary, the *almanah* speaks. Now and for all time, she is a tireless advocate on behalf of all humanity.

III. THE ORDER OF WIDOWS IN THE EARLY CHURCH

What would a community look like if it brought the *almanah* into its center rather than pushing her to its margins? By turning to the community created by the early Church, we might gather some clues. As historians have emphasized, women played a significant role in building and sustaining the Church, as ministers, patrons, prophets, and martyrs in service of the Lord and Christ.[10] Many of these women were not marginalized but socially powerful, such as Phoebe, who protected Paul (Rom. 16:1–2), or Lydia, the merchant

of purple goods and patroness of the apostles (Acts 16:14ff) (Meeks, 1983, pp. 59–60). At the same time, early Christians took seriously their obligations to support the vulnerable persons in their midst, including the widows. In the Acts of the Apostles (Acts 6:1–7), we learn that one of the first controversies that faced the infant Church was prompted by the fact that the Hebrew widows received a greater share of the daily distribution than the Hellenist widows. By the middle of the third century, the Church at Rome cared for fifteen hundred widows and other poor persons (P. Brown, 1988, p. 148).

Given the social circumstances of the time, it is not terribly surprising that the Christian community drew upon the beneficence of wealthy women, nor that it sustained a group of women who were vulnerable (Stark, 1995, pp. 229–44).[11] What is remarkable is the innovative conjunction of giving and receiving assistance that characterized the relationship between the early Church and the widows. It echoes the multitiered relationship between the mother of Jesus and the beloved disciple in the Gospel of John. The early Church did not limit its involvement with the widows to material support, nor allow them merely passive membership in the community. Through an Order of Widows, the Church recognized the contribution that the widows could make to the well-being and spiritual growth of their fellow believers.[12]

The Order of Widows can trace its biblical roots to 1 Timothy, where its qualifications for membership are listed alongside the qualifications for the ecclesiastical offices of bishop, deacon and elder. These qualifications include age (a widow must be sixty years old), only one marriage (widows must remain continent after their husbands die), and a history of good deeds. The early Church did not deny material assistance to needy and unqualified widows; at the same time, it gladly collaborated in the work of the Lord with wealthy and powerful women. Nonetheless, only a “real widow” — that is, a true *almanah* who met the additional qualifications of advanced age and virtuous character, was eligible to “enroll in” or be “appointed” to the Order of Widows.

The primary duty of the Order of Widows was to pray ceaselessly on behalf of the community; their pleas are powerful because God hears the cries of the oppressed. Although theirs was not a ministry of the altar, they exercised spiritual authority and influence in their ministry to the community. Widows made house visitations, where they comforted, fasted, and prayed with the sick and gave practical instruction to younger women. They prophesied. Enrolled widows also assumed a place of honor in the liturgy, sitting in the front of the assembly along with the bishops, priests, and deacons.[13] Repentant sinners seeking reconciliation with the community prostrated themselves before the widows, as well as before the presbyters (Gryson, 1976, p. 21).[14] Such prostration was symbolically fitting, because the life of a widow was not just an ideal woman’s life, but also an ideal

Christian life. In the early Church, a common metaphor for the widow was the "altar of God," which Bonnie Thurston convincingly argues should be interpreted in an active rather than a passive fashion, since the widow is a *living* altar. "Christ provides the atonement through his sacrifice; the altar reminds Christians of his sacrifice. (Heb. 13:10). The widow, by her way of life, is an example of Christ's 'one, full, perfect and sufficient sacrifice'" (Thurston, 1989, p. 111).[15]

IV. THE ORDER OF WIDOWS, THE VIRTUE OF SOLIDARITY, AND CONTEMPORARY WOMEN'S HEALTH

Needless to say, there is no Order of Widows in the contemporary Church. Historians tell us that it declined in importance after the beginning of the fourth century, as many of its functions were assumed by deaconesses and later, by monastic women.[16] Nearly two thousand years after the birth of the Church, we find ourselves in very different cultural circumstances than those of the early followers of Jesus. Can a long-defunct order composed of elderly women illuminate the complex problems of women and health care we face today? Yes. At the heart of Christian anthropology stands an eternal truth: All women, no less than all men, possess an intrinsic dignity and command a fundamental respect because they are made in the image and likeness of God. In the Order of Widows, the early Church made the power of this insight manifest.

To use the language of contemporary Catholic social teaching, the early Christians exercised the virtue of solidarity through the Order of Widows. That virtue requires far more than a willingness to give alms to the needy from a safe distance. It also calls for a willingness to enter into a communal relationship with other human beings simply because they too are made in the image and likeness of God. The hallmark of solidarity is the refusal to condition a person's social participation upon her ability to meet a set standard of social usefulness.[17] Unlike an instrumentalist account of human value, which asks potential members what they can contribute before admitting them to the community, solidarity's first move is to extend membership. Only then does it begin discerning how the new member can contribute to the common enterprise.

Precisely because solidarity refuses to be bound by the standards of utility commonly used to assess one another's worth, it requires *creativity and flexibility* in identifying just how previously marginalized members might make their contribution. The true innovation in early Christian communities was not in coming to the aid of the widows, which had been long considered a meritorious act by the Israelites. Nor was it in simply acknowledging them as members of the community. Rather, it was in discovering genuine

ways in which the widows could aid others, thereby creating an innovative form of social unity.

Because it is the body of Christ, the unity of the early Church, like that of the Church today, is an embodied unity. It takes its integrated form and purpose from Christ, its head. The innovative solidarity practiced by the early Church is fully intelligible only in the context of its own sacramental life, which is rooted in Christ and continually nourished by his Spirit. Nonetheless, the Church's mission is to proclaim Christ's truth to the nations, because he came to save all men and women. We recognize that all human beings, whether or not they are Christian, have a limited but real capacity to grasp this truth because they too have been created in the image and likeness of God. Thus, as we turn to the contemporary situation, the task of Christian ethics is to discern the requirements of solidarity with elderly women by drawing fully on the special sources of insight available to the Church, including the example of the early Christians, as well as to nurture points of consonance with all people of good will.

The call to respect the intrinsic dignity of each and every human being — including each and every *female* human being — has not lost its urgency. Despite the great strides that humanity has made in recognizing the dignity of women, strong tendencies to value women solely according to their rank on a scale of social utility are still prevalent in the contemporary world.[18] Furthermore, sin goes hand-in-hand with deception, both of others and of ourselves. It is not unheard of for policy makers to invoke the language of women's autonomy in order to hide the fact that their programs actually reduce women solely to their instrumental value to society.[19]

Is there any way to forestall such deception? Perhaps not entirely, since the temptation to reduce others to their instrumental value lingers in all human hearts, including our own. Nonetheless, the model furnished by the early Christian order of widows can provide us with helpful guidance, particularly when used in conjunction with Catholic anthropology and social teaching to illuminate its force in the contemporary context. More specifically, an approach to women's health that emphasizes solidarity with elderly women is not only sound in itself, it is also less likely to reduce younger women to their instrumental value in service of social goals.

Current statistical projections indicate that the health needs of elderly women will assume increasing importance during the first half of the twenty-first century. To put the matter bluntly, the future is elderly and female. In 1900, one in twenty-five Americans was over the age of sixty-five. The U.S. Census Bureau (2004) projects that by the year 2030, *one in five* Americans will be over sixty-five, as the baby-boom generation moves from its middle years into old age. The most dramatic increase in the elderly population is occurring among the group aged eighty-five and older, the so-called "old old" (Taeuber and Allen, 1993, p. 12). Let no one here

make the mistake that the aging of the population is a peculiarly American phenomenon. This trend also characterizes other countries in the first world; by the year 2025, Japan is predicted to have twice as many elderly persons as children. More remarkable, however, is the fact that it is in the *developing* countries that the elderly population is growing most rapidly. The elderly population of Indonesia, Liberia, Thailand, and Colombia is expected to *quadruple* between 1990 and 2025 (Steel, 1997, p. 1374).

Because women live longer than men, they are more likely to dominate the ranks of the elderly and of the "old old." In 1990, women comprised about two-thirds of those belonging to the over-sixty-five age group and three-fourths of Americans older than eighty-five. In many of today's cultures, poor, elderly women find themselves at the very bottom of the scale of social utility, just as they did in the biblical world. Many such women have outlived their husbands. They are not sexually desirable, are unable to bear children, and are deprived of the strength of youth. Not only do they fail to take care of others in the manner expected of women, they may even require such care themselves. Unlike unborn or infant girls, old women cannot even offer the prospect of *future* instrumental value.

Unfortunately, despite the rapidly growing numbers of elderly women, their health needs have until recently received scant attention from either the feminist or human rights communities.[20] A prominent example of this virtual invisibility can be found in *The Declaration and The Platform for Action* (United Nations, 1996, pp. 56–72) of the Fourth United Nations Conference on Women held in Beijing, China in 1995.[21] Of the seventeen numbered paragraphs setting forth the Conference's strategic objectives for women's health care, only one brief paragraph focuses on the needs of aging women.[22] In contrast, eight long paragraphs are devoted primarily or exclusively to the promotion of women's sexual and reproductive freedom!

Thus the contemporary discussion of women's health badly needs the perspective of intellectuals and activists explicitly committed to solidarity with elderly women. Drawing inspiration from the Order of Widows in the early Church, contemporary Christians have a tremendous opportunity to contribute to the discussion at just this point. I believe that the virtue of solidarity requires of us today the same three-fold activity practiced by the early Christians toward the widows in their midst.

First, we must focus on the material needs of elderly women, striving to overcome their health problems as best we can with the resources we have, just as the early Christians tried to meet the needs of the widows for food, clothing, and shelter. Human ingenuity can be employed to promote good health and combat illness and disability, at both the level of individuals and of whole populations. *Health care*, properly understood, encompasses far more than *medical* care. Adequate nutrition, housing, sewage systems, and a basic educational and income level are also key factors.[23] Furthermore, good health requires a stable political and social environment to eliminate

war and minimize violence. In short, good health depends not just upon enabling access to basic medical care, but also upon securing a range of intersecting personal, social, economic, and political rights.[24]

Second, because not every illness can be cured and not every disability can be prevented, we must minimize their harmful effects, in particular the isolation they inflict upon their victims. In the words of the great Protestant ethicist Paul Ramsey, "If the sting of death is sin, the sting of dying is solitude . . . Desertion is more choking than death, and more feared" (1970, p. 134). The early Christians did not leave their widow to die — or to live — in solitude and loneliness; neither can we.

Finally, we need to facilitate the continuing role of elderly women in our society, even if we cannot eliminate their physical problems. According to the medical philosopher Eric Cassell (1991), the mark of human suffering is a sense of purposelessness, a sense that life no longer holds anything for them to accomplish. If we are to alleviate the suffering of elderly women, and not merely their physical pain, we must enable them to play a positive role in the community.

V. THE THREE-FOLD INTEGRATIVE FUNCTION OF HEALTH AND THE NEEDS OF ELDERLY WOMEN

The challenges posed by the call for solidarity with elderly women can be better understood if we focus on their specific needs in the context of an adequate understanding of health and illness. Why is good health such a great blessing? Conversely, why are illness and disability such curses, particularly if they are serious or prolonged? The World Health Organization (2004) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." While this definition clearly needs specification, it does furnish a sense of the sweeping impact that health status can have both upon individuals and the communities in which they live.

On three different levels of human existence, good health is integrative; it moves human beings toward wholeness. First, good health enables persons to experience themselves as integrated on a personal level, as embodied souls. Second, good health enables human beings to integrate themselves within their broader society. Third, good health enables persons to experience themselves as integrated on a vocational level, empowered to work out their response to God's particular call to them. Conversely, serious or prolonged illness or disability threatens to destroy this integration. It is the three-fold task of solidarity to do what it can to overcome the division that bad health can bring on all three levels. Let us look more closely at each of these levels, as well as the particular challenges they pose for elderly women in the contemporary world.

A. Personal Integration

First, good health facilitates integration *within* each human being who possesses it. The possession of good health enables human beings to recognize ourselves as we are, as psychosomatic unities whose bodies, minds, and souls are designed to work together in harmony. Human beings are essentially embodied creatures. As the discoveries of human genetics teach us, to be embodied is to be particular; there is no such thing as a generic human person. We are embodied as male or female, as the recipients of a particular racial or ethnic heritage, as young, middle-aged, or old, as susceptible or resistant to particular diseases. The fundamental goodness of this embodied human existence is revealed in the incarnation of Jesus Christ, who walked the earth two thousand years ago as a particular man with a determined heritage and a specific course of life.

Because it both honors and reveals the fundamental goodness of embodied human nature as created by God, good health is intrinsically valuable. In sharp contrast, illness and death do not accord with God's ultimate plan for us; they are the bitter consequences of humanity's original sin. In his resurrection from the dead, Christ conquered the ultimate destructiveness of illness and death; nonetheless, their painful effects remain an aspect of human existence that will not be overcome until the coming of the Kingdom. However, as brothers and sisters of Christ, we are secure in the hope that those effects will indeed be vanquished. Because we share in his death, we will one day share in his resurrection to a gloriously transfigured embodied human existence.

This firm hope in the bodily resurrection of the dead, which Christians proclaim in the Nicene Creed, has radical implications for Christian anthropology and ethics. In particular, it reveals that an individual's proximity to death can never have the power to erode the goodness of her embodied existence per se. The power of the resurrection transforms our distorted, utilitarian understanding of the value of human embodiment. Secure in its promise, we can see that the embodied life of an elderly or gravely ill human being cannot be any less than good in itself, just because it approaches the end of its appointed span of years. Consequently, the obligation to respect the embodied existence of the elderly, disabled, and ill remains in full force, although the concrete form that this obligation takes can shift to meet their changing needs.[25]

Nonetheless, serious illness or disability frequently threaten to dissolve a person's own *experience* of psychosomatic unity and the goodness of human embodiment. A seriously ill or disabled person can find herself caught in a crossfire that pits her malfunctioning body against a mind that desires to continue living and moving.[26] Sometimes, the body may even be divided against itself. In his best-selling book *How We Die*, the physician Sherwin Nuland invokes the imagery of gang warfare to describe the

destruction that cancer cells can unleash upon the human body that gave them life. He writes,

> [cancer]'s first cells are the bastard offspring of unsuspecting parents who ultimately reject them because they are ugly, deformed, and unruly. In the community of living tissues, the uncontrolled mob of misfits that is cancer behaves like a gang of perpetually wilding adolescents. They are the juvenile delinquents of cellular society. (1995, p. 208)

The internally divisive experience of illness exacerbates the tendencies of contemporary Western cultures to fall into one of two forms of dualism. On the one hand, it is tempting for many people to identify their true "selves" exclusively with an inner, nonmaterial core rather than with the whole unique physical, mental, and spiritual complex that makes up an embodied human person. On the other hand, others reduce an embodied human person solely to her body, to the market value of the fragile and changing corporeal aspect of her nature.

As they play themselves out in contemporary medicine, both of these dualistic tendencies have harmful consequences for the well-being of women, particularly elderly women. While the first type of dualism encourages us to ignore the distinctive features of their embodied existence, the second type tempts us to denigrate its importance. By forcefully advocating a nondualistic anthropology that proclaims the dignity of embodied human women in all their particularity, we can imitate our forebears in the early Church and demonstrate solidarity with the elderly, vulnerable women of our time. More specifically, we can call attention to the imperative to address the *specific* health care needs of such women.

For example, an anthropology that emphasizes the integral relationship between body, mind, and soul will immediately see that the practice of conducting medical research using only a homogeneous group of experimental subjects is flawed at its inception. From the perspective of a nondualistic anthropology, it is not surprising that illness and disease take different paths and require different treatment in persons who are embodied in different ways. Nonetheless, until very recently, the majority of American medical research on heart disease was conducted by limiting enrollment in clinical trials to white, middle-aged males, despite the fact that elderly women suffer the highest rates of morbidity and mortality from this disease (Guwirtz, Col, & Avorn, 1992, pp. 1417–22). A direct consequence of excluding elderly women and other vulnerable populations from research protocols can be that they do not receive medical care specifically tailored to their needs. Moreover, they also may be less likely to be treated with procedures that have proven effective in white, middle-aged men.[27]

Until very recently, this sort of discrimination has pervaded medical research in the United States. In particular, many of the afflictions associated

with aging have been studied in male research subjects, to the extent they have been studied at all (Task Force on Older Women's Health of the American Geriatric Society, 1993, pp. 680–83). There is, however, some cause to hope that the tide may be turning; in 1993, the federal government began requiring the National Institutes of Health to include women and minorities in research programs funded by the U.S. government (Eisenberg, 1995, pp. 183–89).

Moreover, an anthropology that honors the well-being of all persons in their psychosomatic unity would not permit the medical system to ignore the damage done by diseases that specifically target women, particularly elderly women (see Rosser, 1994). For example, Medicare, the American program of health insurance for the elderly, long provided better coverage for the acute illnesses commonly suffered by old men (such as lung cancer, acute myocardial infarction, or prostrate disorders) than the chronic diseases more likely to afflict old women (such as osteoporosis, depression, or arthritis) (Clancy & Massion, 1992, 1918–20). The fact that a disease is chronic rather than acute does not mean it is any less devastating. Consider the problem of osteoporosis, which affects 30 percent of postmenopausal women and is one of the major causes of wrist, spine, and hip fractures suffered by that group (Ilich, Badenhop, & Matkovic, 1996, 194). In the United States, about 250,000 older people, mainly older women, suffer hip fractures each year. Nearly half of them are never able to walk independently again (Fahs, 1993, pp. 123–24). This type of injury is frequently a "one-way ticket to a nursing home" for the woman who suffers it (Cohen & Cahan, 1993, 361). It deserves more attention from the medical community.

Thus at the first level of meaning of health and illness, which focuses on integration within the embodied person herself, solidarity calls us to address the particular medical needs of elderly women today, just as the early Christians met the particular material needs of the widows in their time.

B. Social Integration

A second integrative function of health pertains to the essentially social nature of human persons. We are called to live in community. Good health enables individuals to participate freely and easily in the activities that characterize human life, such as negotiating the hustle and bustle of the crowded marketplace, attending public events, caring for a family, or surmounting the challenges of a contemporary work environment. In contrast, serious illness, disability, or the infirmities of old age can bring an isolation that stems from two distinct sources, one internal to the person herself, the other externally imposed by the wider society. More specifically, illness deprives persons of the strength and mobility necessary to navigate many public spaces. Some isolation is an inevitable consequence of illness, unless the surrounding community actively reaches out to include the sick

individual. The immobility and isolation caused by hip fractures exemplifies this phenomenon.

However, in many cases, that community not only refuses to reach out, it maintains and even expands the isolation of those who are not in good health. Some diseases, such as leprosy or AIDS, carry with them a strong social stigma. Carriers are often perceived not only as contagious (which they may or may not be) but also more fundamentally as unworthy and "unclean." Disabled persons shatter our illusions of invulnerability, reminding us of our own precarious hold on life. We isolate the seriously ill, the disabled, and the elderly because we are afraid of them.[28] The objects of such isolation frequently internalize these negative perceptions, even to the detriment of their own treatment. For example, Dr. Sherwin Nuland writes of encountering women who were so ashamed of having breast cancer that they did not seek medical attention until the disease had eaten away their chest walls (Nuland, 1995, p. 215).

Grim U.S. statistics demonstrate the tenuousness of the bonds connecting elderly women to the broader community, which is largely due to two interrelated factors: lack of a supportive family structure, and lack of financial resources. First, while most elderly men are married, most elderly women are not. Because of the different life expectancies of men and women, as well as the tendency of women to marry older men, 74 percent of American men older than sixty-five still have living wives, while only 40 percent of women over that age still have husbands who are alive. Moreover, elderly women are far more likely than elderly men to live alone. According to the 1990 statistics, 80 percent of the 9.2 million elderly persons living by themselves are female. One out of three elderly women who are not institutionalized lives by herself.

Second, elderly women are far more likely than their male counterparts to be poor or nearly poor. While women counted as 58 percent of elderly Americans in 1990, they comprised nearly 75 percent of the *impoverished* elderly (Taeuber & Allen, 1993, p. 23). Nearly one in three elderly women had an income level less than 150 percent of the poverty level. Furthermore, among older women, poverty is disproportionately concentrated among those who live alone and members of minority groups (Malveaux, 1993). Poverty has a direct effect on health. A recent study in *The New England Journal of Medicine* concluded that "sustained economic hardship leaves physical, psychological, and cognitive imprints that decrease the quality of day-to-day life" (Lynch, Kaplan, & Shema, 1997, 1895).

The situation of elderly women is not better when viewed in a global context.[29] According to sociologist Helena Lopata, the well-being of widows depends upon their access to four systems of social support: economic support to meet their material needs, service support to perform tasks they can no longer do themselves, social support to forestall loneliness, and emotional

support to assuage grief. Lopata's cross-cultural studies of widowhood demonstrate that these support structures are highly culturally dependent and sensitive to social change (Lopata, 1980; 1987a; 1987b; 1996). As a consequence, many widows in developing countries face unanticipated problems as they discover that the social framework they had counted on to protect them is no longer in place.

For example, Lopata recounts how, in traditional Korean or Turkish societies, the duty to support an elderly woman falls upon her son; in fact, she would expect a place of honor in his household. Yet modernization and industrialization has taken many young men away from their ancestral homes to cities and even out of the country in pursuit of employment (as many young Turkish males have moved to Germany). Under such circumstances, these men often shift their focus to their own wives and children, ignoring their responsibilities to their mothers (Lopata, 1987a). Many elderly women now wonder who will take care of them when they can no longer take care of themselves.

Just as the early Christians drew the boundaries of their communities to include rather than exclude the widows, so the virtue of solidarity requires us to do the same today. In so doing, we must confront the challenges of particularity on a global level. While the vulnerability of the *almanah* is universal, the specific social structures necessary to protect her will vary from culture to culture. In particular, countries in the developed world must encourage societal evolution to take place in the developing world in ways that do not strip elderly women of their traditional support structures without immediately replacing them with new ones.

C. Vocational Integration

The third integrative function of health builds upon the first two functions. Each human being, who is always an embodied and social being, is called to live out a particular vocation in creative fidelity to a divine call. By allowing persons to depend on the internal integration of body and soul, as well as to move freely in social settings, good health facilitates a wide range of vocations. Consequently, serious illness, disability, or even old age can trigger far more than a physical crisis; it can also trigger a crisis of identity and ultimately, a crisis of faith. People who find that their health prevents them from fulfilling their obligations to their family or their profession may despair of life's meaning altogether. Like Job, they may even believe themselves to be forsaken by God, plunging into the most devastating isolation of all.

A major impediment to facilitating the vocational contributions of elderly women is the combination of ageism and sexism in the workplace. According to a 1989 survey, 1.1 million men and women over fifty are able

and willing to work but are nonetheless unemployed. Over one-third of these individuals believed that employers would think them too old to hire. Studies have established that age discrimination can affect women beginning at age forty. In addition, women may be unjustly penalized in their search for employment because their commitments to raising a family prevented them from establishing the type of continuous work history valued by many employers (Rayman, Allshouse, & Allen, 1993, pp. 142–3). Although federal law now prohibits discrimination on the basis of age and sex, many victims lack the ability and will to mount a legal challenge against unjust employers.

An additional problem is that most societies continue to undervalue work that has traditionally been done by women. Despite the well-publicized gains of the women's movement, the majority of women continue to work in traditional female occupations, such as sales, service and clerical positions. 1989 statistics for the United States demonstrate that younger women continue to enter these occupations at the same rate as older women. Not only does "women's work" provide a smaller base income than "men's work," it also is less likely to provide the same level of benefits. For example, traditionally female jobs are less likely to offer pension plans or even health insurance, which is not a universal benefit in the United States (Barusch, 1994).

Yet the most pressing problem is that much of the work that women do is not only undervalued, it is entirely invisible to the social system. For many women, a large part of their lives is devoted to caregiving; they take care of children, spouses, and aging parents. Not only is this work uncompensated, it brings no fringe benefits such as health insurance or retirement income. This situation is particularly problematic when we look at the dynamics within the elderly population itself.

According to the data from a broad U.S. survey conducted by the Select Commission on Aging, the average caregiver for the disabled elderly is a fifty-seven-year-old woman. 36 percent of caregivers are older than sixty-five themselves. Unpaid caregiving is a grueling business; 80 percent of caregivers said they provide care seven days a week. Because of its intensity, caregiving can force a middle-aged or "young old" woman to cut back her own paid employment. Thirty-five percent of working daughters altered their work schedules in order to care for aging parents. One in eight quits her job entirely (Foster & Brizius, 1993, p. 51). Because our society does not value caregiving, these women are making choices that are nothing less than heroic. In the current American social system, a woman who gives up her job and sacrifices her health insurance in order to care for her aging mother is jeopardizing her own opportunity for security when she reaches that stage of life herself.

The vocational crisis precipitated by old age and increasing disability takes a poignant form in the context of contemporary debates over assisted

suicide and euthanasia (Kaveny, 1998). At least in the United States, the legalization of such practices is likely to harm elderly and disabled women most of all. The vast majority of the infamous Jack Kevorkian's clients have been female. Many of them were not terminally ill, but suffered from chronic disabilities that required a great deal of care from others.

Some of the features of American life that place women at disproportionate risk for assisted suicide or euthanasia have been discussed earlier, such as the increased poverty and lack of support systems characterizing the lives of elderly, ill, and disabled women. Another factor is the prevalence of depression among women, who suffer from this disease at almost twice the rate of men. Yet there is also a more insidious danger. For centuries, women have been socially conditioned to put the desires of others ahead of their own needs. Moreover, whole societies have been conditioned to expect as much from them. Many women may believe that their proper role lies in providing care, not receiving it. This inadequate appreciation for their own dignity and worth may lead elderly and chronically ill women to request assisted suicide or euthanasia to avoid becoming a burden on others. Their families and physicians might very well agree with them. Victims of the enduring sin of sexism, such women will misperceive the choice of their own deaths as the last, best gift they can give to their own aging daughters (see Osgood and Eisenhandler, 1994; Wolf, 1996).

It is very likely that the younger and more vigorous members of the ancient Order of Widows cared for older women in their group. That work was honored, not denigrated, by the early Church. Furthermore, no Christian widow taking care of an older woman would thereby risk her own security later in life. Still less would she have encountered pressure to choose her own death when she began requiring assistance herself. Consequently, a major challenge facing the contemporary Church — and the contemporary world — is to honor the work that women have traditionally done and protect those who are called to do it today. At the same time, we need to recognize that many women, such as female doctors, lawyers, and professors, are truly called to vocations that were once limited to men. Finally, remembering that the virtuous widow lived an ideal Christian life, not merely an ideal woman's life, we also must encourage men to engage in the honorable tasks of caregiving.

VI. CONCLUSION

In the Order of Widows, the early Christians gave us a vivid example of how a society can be organized to manifest solidarity with elderly and vulnerable women. These disciples of Christ met the widows' material needs, incorporated them into the community, and honored their contribution to the common good. Looking at the three-fold integrative purpose of health,

we explored what the virtue of solidarity requires from us with respect to the elderly and marginalized women of today.

However, the transforming power of this solidarity is not limited to the old and isolated women who are its immediate beneficiaries. A society that affirms the equal dignity of such women, despite their lack of utilitarian value, will better resist the temptation to reduce younger women to their instrumental worth. The communities of the early Church provide an example of this phenomenon. Early Christians not only distinguished themselves from the broader pagan culture by the concern they extended to widows. They were also set apart by their rejection of the widespread practices of infanticide and abortion, as well as by their increasingly powerful advocacy of a virginal life. In distinct ways, each of these enhanced the position of female persons in the social context of the Roman world. Victims of infanticide were disproportionately female. Moreover, in addition to its lethal consequences for unborn children, at that time abortion was also highly dangerous for the women who obtained it. Even early Christian tracts advocating a life of virginity, which can seem so repressive to modern ears, explicitly promised liberation from the terrible dangers of childbirth which extinguished the lives of so many young women (P. Brown, 1988, pp. 24–25). This is not to say that the early Church entirely overcame the sin of sexism that has distorted human relations since the Fall. It did not. Nonetheless, the communal life of the first Christians demonstrated, however imperfectly, the transforming power of the virtue of solidarity, exercised in the conviction that every human being is made in the image and likeness of God.

Solidarity does not pick and choose. Commitment to the well-being of all female human beings, no matter what their stage of life, is woven into a seamless garment. How, then, can a firm commitment to solidarity with the *almanah* in our midst affect the approach we take to other pressing questions of women's health? The possibilities are enormous.

For example, consider the family-planning programs that are virtually imposed by first-world countries upon women in the third and fourth worlds. Some of the contraceptive methods that these programs advocate may be physically dangerous for those who use them. Would not a view of women's health that proclaims the intrinsic goodness of the embodied lives of elderly women — despite their lack of utilitarian value — clearly recognize that these coercive contraceptive programs wrongly reduce the bodies of younger women to instruments of social control?

Or consider the way the work force and family life is structured for many women with young children, forcing them frenetically to balance competing obligations to their employers and to their families. Would not a view of women's health that facilitates the social participation of physically limited elderly women also reject these structures as insufficiently attentive to the specific needs of exhausted working mothers of young children?

Finally, consider the issues surrounding the use of reproductive technologies. Despite their great expense and low success rates, many infertile women continue to seek them out in order to have biological children. Would not a view of women's health that honors the social contribution of aged and infirm women also proclaim that the intrinsic dignity of a younger woman is not compromised because she is physically unable to conceive and bear a child? Would this not enrich our understanding of a true ethics of care, thus giving substance to a Christian bioethics of care?

What should be our goal as we rethink issues affecting women's health in light of the imperatives of solidarity? Nothing short of the transformation of human societies and cultures so that each and every female human being, no matter what her age, status, or level of physical dependency, can recognize echoes of her own dignity in the exclamation of a poor Jewish woman who stood at the side of Jesus' cross. Two thousand years ago, this particular Jewish virgin freely consented to the will of God and changed the course of human history. Let me close with the words of Mary's Magnificat:

> My soul magnifies the Lord,
> and my spirit rejoices in God my Savior,
> for he has looked with favor on the lowliness of his servant.
> Surely, from now on all generations will call me blessed;
> for the Mighty One has done great things for me;
> and holy is his name. (Luke 1:46–49).

NOTES

1. All of my own citations from Scripture are taken from *Holy Bible*, New Revised Standard Version (Catholic Edition).

2. "When Naomi, Ruth's mother-in-law, comes to Bethlehem, she laments, 'Do not call me Naomi [pleasant], call me Mara [bitter], for the Almighty has dealt very bitterly with me . . . The Lord has afflicted me and the Almighty has brought calamity upon me.'" (Ruth 1:20–21). In a song of assurance to Israel, the prophet Isaiah promises, "the reproach of your widowhood you will remember no more" (Isa. 54:4)" (Thurston, 1989, p. 13).

3. See, e.g., Hiebert, 1989. The main evidence cited for this conclusion are specific provisions of Middle Assyrian Laws, which nearly always use the Akkadian term *almattu* in a way that is consistent with the use of *almanah*, its Hebrew etymological equivalent, in biblical legal codes.

4. Laws from the other polities in the ancient Near East made similar provisions.

5. R. Brown (1982, p. 91) observes that John's use of hyssop in the passage that concerns us "is strange until we remember that hyssop dipped in the blood of the *paschal lamb* was used to smear doorposts as a sign of God's protection in the Jewish Passover re-enactment of the Exodus."

6. According to Raymond Brown (1982, pp. 22–23), it is symbolically significant that in neither the crucifixion scene nor in the earlier passage describing the wedding at Cana (John 2:1–11) does Jesus address his mother by name. Instead he uses the term "woman," a polite form of address that "is strange and without parallel" for a son to use in speaking with his mother. Brown concludes that "by the strange use of 'woman' . . . John seems to indicate that Jesus rejected a purely human sphere of action for Mary to reserve for her a much richer role, viz., that of a mother caring for those who would follow him."

7. There is a considerable range in the symbolism assigned to Mary on the basis of this biblical passage. Mary can be seen as herself, the mother of Christ, becoming *mother* to the Church that is symbolized by the beloved disciple. She has also been seen as a *type* of the Church, given to the care of the apostles represented by the beloved disciple. Just as she is the mother of Christ, the head, so the Church is the mother of the faithful, Christ's body. For a helpful discussion of the biblical warrants of various symbolic interpretations of this passage, see R. Brown, 1970, pp. 922–27. See also Hans Urs von Balthasar's (1992, pp. 283–360) erudite discussion of the theological ramifications of the use of a wide range of Marian symbolism over the course of the Church's history.

8. For a helpful discussion of other women in the Gospel of John, see R. Brown, 1979, pp. 183–98.

9. Vatican II, 1964, ¶ 62. "Taken up to heaven she did not lay aside [her] salvific duty, but by her constant intercession continues to bring us the gifts of eternal salvation. By her maternal charity, she cares for the brethren of her Son, who still journey on earth surrounded by dangers and difficulties, until they are led into the happiness of their true home."

10. Detailing the more prominent role played by women in the early Church than in pagan societies of that time, Stark (1995, pp. 229–44) argues that such prominence is sociologically correlated to the more equitable gender balance found among Christians, due in part to its prohibition of abortion and infanticide. In contrast, female infanticide was widely practiced even by large pagan families, who rarely raised more than one daughter. Stark cites a study of inscriptions at Delphi which show that of six hundred families, only six had raised more than one girl to adulthood. See also P. Brown, 1988, pp. 140–59; and Meeks, 1983, pp. 59–60, 70–72.

11. Wayne Meeks (1983, pp. 84–94) argues that one of the most distinctive features of the church of the Apostle Paul was the intense, almost familial bond between its members.

12. My discussion of the nature and functions of the Order of Widows depends primarily on Thurston, 1989 and Gryson, 1976,.

13. While there is scholarly agreement that Tertullian ranked widows among the clergy, there is disagreement about what their place was in other writings from the early Church. For example, Thurston (1989, pp. 104–105) suggests that although they did not preside at liturgy, they were widely considered to belong to the clerical ranks, while Gryson, 1976, (pp. 110–111) concludes that widowhood was not a clerical function but a "state of life" with canonical status similar to the secular institutes of today.

14. This use of the metaphor occurs first in Polycarp's Epistle to the Philippians (written at the beginning of the second century); it appears also in the *Didascalia Apostolorum* (written in Syria in the first half of the third century) and in the *Apostolic Constitutions* (written in Egypt at the beginning of the fourth century).

15. As both Thurston and Gryson document, much of the literature dealing with widows warns against morally inappropriate behavior on the part of members of the Order (e.g., gossiping, jealousy, laziness, love of money and dainties) or restricting their range of legitimate functions (e.g., several writers emphasized that widows were not to teach religious doctrine nor to baptize).

16. In part, the decline of the order is attributable to the controversies about the role of women in the early Church, which was initially far more prominent than in Jewish or pagan societies of that time. Early Christians struggled with how to develop roles for women that were consonant with the will of Christ, supported by the anthropological assumptions of the time, and calculated not to bring the derision of pagans down upon the fledgling Church. Peter Brown (1988, p. 140) notes that a common pagan prejudice against the early Church was that the close working relationships of the "brothers and sisters in Christ" were transparent disguises for promiscuous behavior.

17. Needless to say, the concrete requirements of solidarity will vary, depending upon the scope and purpose of the community at issue; we have different obligations to our family members, fellow townspeople, parishioners, citizens of the nation, and inhabitants of the globe.

18. In his Apostolic Letter on the Dignity and Vocation of Women (1988, ¶10), Pope John Paul II directly relates domination and injustice in the relationship between men and women to original sin.

19. There is precedent for such use of the language of autonomy in the American constitutional tradition. In the first third of this century, the United States Supreme Court adopted a jurisprudence that struck down as unconstitutional laws enacted to provide workers with minimally acceptable working conditions, on the grounds that such laws interfered with the right of workers "freely" to negotiate a contract with the powerful corporation that employed them. The Court ignored the vast disparity in power, education, and need between the two parties to the contract. This jurisprudence was not abandoned until President Franklin Roosevelt threatened to "pack" the Court with his supporters in order to ensure the survival of his New Deal program. See Chemerinsky, 1997, pp. 474–94.

20. For example, while ten articles in the anthology *Feminist Perspectives in Medical Ethics* (Holmes & Purdy, 1992) treat pregnancy and reproductive technology, only two essays focus on age or disability issues. Despite its general title, *Evaluating Women's Health Messages* (Parrotte & Condit, 1997) deals *entirely* with women's reproductive health.

21. For an article explaining and evaluating the impact of religion, laying out the religious objections to the Platform, see Dormady, 1997, pp. 97–135.

22. The Holy See expressed a general reservation to the section on "Women and Health." For the perspective of Mary Ann Glendon, the head of the Vatican delegation to the conference, see Glendon, 1996 and Glendon, 1997. Glendon writes (1996, p. 30) "Reading the drafts overall, one would have no idea that most women marry, have children, and are urgently concerned with how to mesh family life with participation in broader social and economic spheres." Ironically enough, given that most of the delegates in the conference were in their late forties, fifties or sixties, one would also have no idea that women grow old!

23. How a society should distribute goods in situations of scarcity is also an important moral question. In many societies, such goods are distributed in a way inconsistent with the equal dignity of all human persons. See Nussbaum, 1995, p. 3: "When there is a scarcity, custom frequently decrees who gets to eat the little there is, and who gets taken to the doctor." Nussbaum draws on the work of Amartya Sen to highlight the fact that in countries where there is little sex discrimination in the provision of health care, the ratio of women to men is greater than 1:1, no matter how low or high the standard of living. For example, in 1986, the female-to-male ratio was 1.05:1 in Europe, and 1.022:1 in sub-Saharan Africa, where there is great poverty but women have substantially equal access to the little health care that there is. Sen calculated the number of "missing women" of a number of nations whose culture values the lives of women less than the lives of men by asking what their female populations would be if their female-to-male ratio was the same as that of sub-Saharan Africa. "The number of missing women in south-east Asia is 2.4 million, in Latin America 4.4, in North Africa 2.4, in Iran 1.4, in China 44.0, in Bangladesh 3.7, in India 36.7, in Pakistan 5.2, in West Asia 4.3."

24. For a discussion of various types of human rights, see Hollenbach, 1979, chap. 4.

25. This does not deny that proximity to death can alter the concrete shape that some of those obligations take, as the Catholic moral tradition has recognized in developing the distinction between ordinary (proportionate) and extraordinary (disproportionate) means of medical treatment. It does not weaken, however, the prohibition against intentionally taking human life. See John Paul II, 1995, 64–67.

26. For a compelling description of how torture inflicts physical pain in order to disintegrate the mind and will of the tortured person for political purposes, see Scarry, 1985.

27. Some studies, however, suggest that the disparity in effective treatment for men and women might not be that great. See, e.g., Malacrida et al., 1998, pp. 8–14, and Pearson et al. 1992, pp. 1883–89.

28. See Vatican II, 1965, ¶ 18: "It is in the face of death that the riddle of human existence grows most acute. Not only is man tormented by pain and the advancing deterioration of his body, but even more so by a dread of perpetual extinction."

29. For helpful descriptions of how the social meaning of aging varies across cultures, see the essays in Sokolovsky, 1997.

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