Palliative Care's Sacramental and Liturgical Foundations: Healthcare Formed by Faith, Hope, and Love

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PALLIATIVE CARE'S SACRAMENTAL AND LITURGICAL FOUNDATIONS:
HEALTHCARE FORMED BY FAITH, HOPE, AND LOVE

by

Darren M. Henson, B.B.A, M.Div., S.T.B., S.T.L

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ABSTRACT
PALLIATIVE CARE’S SACRAMENTAL AND LITURGICAL FOUNDATIONS: HEALTHCARE FORMED BY FAITH, HOPE, AND LOVE

Marquette University, 2014

Medical history identifies Dame Cicely Saunders as the founder of modern hospice and palliative care for the unique care she gave to the incurably and terminally ill. Less known is how her Christian faith, combined with her knowledge of medicine, influenced her vision. This work retrieves the Christian roots of palliative care and asserts that the practice of faith preserves the practice of medicine from succumbing to medicalized dying—a phenomenon that excessively relies on technology with the implied hope that it will ultimately conquer illnesses and even death.

Efficiency and effectiveness ground modern medicine’s epistemology. These concepts follow the philosophical ideals of the essence of technology asserting that it can and ought to use and control nature to ameliorate problems, including the progression of human illness, frailty, and death. Scholars observe how this forms a medical environment that almost exclusively views death as failure. Christianity, however, forms believers in the paschal mystery of Christ Jesus whose resurrection redeems death.

I argue that the sacramental-liturgical practices of the Christian faith enable healthcare practitioners and patients to renegotiate an understanding of health, death, and life. The celebrations of baptism and Eucharist give the gifts of faith, hope, and love. These rituals form the believer in the pattern of the paschal mystery—the life, death, and resurrection of Christ, and the believer is sent forth to live this in the world. This means that Christians ought to engage medicine differently, in ways that stymie medicalized dying. The practice of faith remains evermore important especially for Catholic healthcare as it increasingly relies less on the women religious who founded these ministries and more on lay professionals whose commitments to living the paschal mystery are less certain. By encountering God’s gratuitous love in the sacraments, one learns to lovingly bear the burdens of illness and also how to create healthcare systems that benefit the common good. The result of this vision of care necessitates the cooperation of both local parishes and large healthcare systems to fully enact the gospel call to lovingly care for the vulnerably ill and dying.
ACKNOWLEDGEMENTS

Darren M. Henson, B.B.A, M.Div., S.T.B., S.T.L

The space under the heading of author reflects only one name, and yet a tapestry of relationships have sustained and nurtured this work. This is an academic work reflecting the knowledge others have gifted to me. I am grateful for my co-workers at the Mercy Health System in Kansas who taught me about the real, lived experience of Catholic health ministry. At Mercy’s system office Dr. Brian O’Toole supported the temporary departure from my career and ministry.

In Milwaukee I found encouragement in the local bioethics community especially from Dr. Ryan Spellecy and his colleagues at the Medical College of Wisconsin and from Dr. Mark Repenshek who opened many doors during the fellowship year. At Columbia-St. Mary’s I gained invaluable experience and insight in the close collaboration with the interdisciplinary clinical teams.

This work is not just about medicine and bioethics but also the prayer of the church. I am indebted to the people of Sacred Heart Parish and Visitation Parish whose life of liturgical prayer has nourished me and demonstrated that our communal prayer and worship does in fact reach the depths of our hearts to renew us in faith, hope, and love.

The struggle inherent in this process would have been more arduous were it not for those who gave me shelter, love, encouragement, their prayers and friendship: Marty, Rick, Michael, Trudie, John, Pat, Stephanie, and Ed. Dr. Mark Plautz generously listened and helpfully provided his own experiences as a critical care physician. The patience of my family could not be more remarkable, and I will forever be grateful for the support from mom, dad, my sister, and brother-in-law. Their health experiences uniquely impact my thoughts on medicine, and they were the ones who planted the seeds of faith and love in the young child I once was.

Lastly, the faculty at Marquette enabled this work possible. Dr. Pat Carey enthusiastically supported my research on the history of Catholic healthcare in America. The members of the dissertation committee have all exceeded expectations for what a student needs and wants in a professor, mentor, and colleague. Dr. Susan Wood, SCL, eagerly welcomed my pioneering efforts in this program. Dr. Bryan Massingale reignited my drive for justice by teaching me about healthcare disparities. Dr. D. Stephen Long saw my potential to be a much better scholar than I ever thought. His generous heart and enviable intellect came to my aid at just the right time. Finally, my deepest gratitude extends to Dr. Ron Hamel. I met him and his CHA colleagues over a decade ago at a continuing education seminar. His patience in my journey has been second to none and his support unfailing. To these persons, to all, and to God, I give my heartfelt thanks.
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**Preface**

The details of when and where I first heard of palliative care escape me, but I do recall that it immediately captivated me. When I worked as member of the administrative leadership team at Mercy Health in their communities in Kansas, I had the privilege of coordinating the palliative care team’s monthly meetings. Fortunately, they had enjoyed some past successes with palliative care at one of their rural acute care hospitals. Memoires of the good experiences sustained a hope for similar future improvements even when their momentum had plateaued. They struggled to garner a critical mass of enthusiasm and dedication among the clinical staff to further integrate palliative care as normative component of the service that a patient could expect at Mercy.

The experiences at Mercy were invaluable particularly when I began my doctoral studies. The passion that exuded from the palliative care practitioners, their dashed hopes for steps toward greater integration, their frustrations, and their determination remained with me.¹ Like any doctoral student seeking to understand the contradictions and complexities I experienced regarding palliative care in the acute care setting, I began reading. Two works frame the problem I seek to address in these pages. Both are written by physicians, and what I find most fascinating is how differently they tell the story of palliative care.

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¹ I need to add a brief note about vocabulary. Throughout this work I use the word “practitioner” to refer to a broad group of individuals in the clinical setting who provide patient care. It includes physicians and advanced care practitioners such as nurse practitioners and physician assistants. It can also include nursing staff, therapists, social workers, and anyone who has direct patient contact in the clinical setting. I use this word in place of the term of “provider,” which refers to clinicians who provide medical services. Caring for the sick and vulnerably ill is an art that one practices, it exceeds merely providing a service. I honor this distinction with my choice of the phrase healthcare **practitioner**.
The first work, authored by Joseph Fins, is *A Palliative Ethic of Care*. As a physician educator, he writes for aspiring doctors. In his opening pages he describes how the modern development of hospice and palliative care emerged in the mid-twentieth century. As every medical history of this specialty describes, Fins identifies Cicely Saunders as the founder of this movement. He notes, “Palliative care has deep religious roots.” Fins draws attention to the Irish Sisters of Charity. They provided refuge to the dying, and Cicely Saunders worked at their St. Luke’s House in London. He cites a prominent medical historian who observed that the hospice movement’s Christian roots filled a void left by scientific medicine’s inability to give meaning and dignity to the dying. Fins ultimately maintains, “that good end-of-life care need not be motivated by a religious orientation—and is itself a secular good.” The remainder of Fins’ book focuses on the clinical realities and leaves unexamined the contributions of religion to medicine.

Because I had previously read the biography of Cicely Saunders, Fins’ editorial decision caught my attention. As will become clearer in Chapter One and throughout the remainder of this work, Saunders’ drive to establish the St. Christopher’s Hospice House flowed both from her practice as a physician and her practice of the Christian faith. This indicates that religious traditions provide something important, if not essential to the modern conception of palliative and hospice care.

A second physician, Jeffrey P. Bishop, who is also a philosopher, presents the inverse of Fins’ position. Rather than removing religion completely from the table of

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4 Fins, 15.
discussion, Bishop posits its possible benefit for medicine. And, rather than viewing clinical medicine as the best possible response to the reality of human finitude, illness, and sickness, Bishop contends that it itself is a key culprit.

My work will respond indirectly to Bishop. I will argue that Dame Saunders’ practice of the Christian faith provided an epistemological center essential to palliative care. I will identify key aspects of the Christian faith that strengthened Saunders’ vision for care for the very elderly, the vulnerably ill, and persons living with chronic and terminal conditions. Then, I will argue that revitalizing similar practices especially in Catholic and other faith-based healthcare institutions, can strengthen and advance palliative care practices today. Rather than hinder the practice of medicine, as Fins implies, religious traditions can serve as an alloy to the practice and experience of palliative care.

**Medicine, Death, and Palliative Care**

Jeffrey Bishop’s argument initially appears counterintuitive, if not complex, and yet it is so intriguing. Standing within the ranks of medicine, Bishop launches a critique of his own discipline, and he has invited others, especially theologians to join the discussion and debate. For these reasons, I want to present a summary of his argument at the start of this work. It serves as an important backdrop to my own work.

In *The Anticipatory Corpse* Bishop provocatively argues that death is at the very core of medicine.\(^5\) He follows Michel Foucault’s genealogical and archeological history of medicine. Eighteenth century discoveries in autopsy practices convinced the leaders in

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\(^5\) Bishop, 8.
medical education not only to emphasize anatomy and physiology, but to establish them as the starting point for medical education. The scalpel revealed things underneath the skin that the doctor’s gaze on the patient’s exterior could not. By knowing more about what lies beneath the skin’s surface, doctors could more poignantly question and probe the patient during the clinical encounter. These Cartesian-inspired practices propelled doctors and their students “to project upon the living body a whole network of anatomopathological mappings: to draw the dotted outline of the future autopsy.” Following Foucault, Bishop connects the medical school cadaver to the patient’s living body. The patient who was once the subject that a disease inhabited, became an object that the physician gazes at, probes, and prods.

In one sense, the dead body provides an ideal training ground for the medical school student and remains a paradigm for the physician. As the cadaver ceases to move and change, a student has total control over it with no deleterious effects. Thus, the student learns the mechanics of bodily systems, the interconnected parts, and how components might be changed or reworked when they fail. The dead body, therefore, “acts as the epistemological foundation of knowledge because it is the stable ground against which the flux of life and disease can be known.” It functions as a prototype overlaid and inscribed on the living, moving, fluctuating bodies of real patients. Students of medicine learn that unless certain critical components within the body function properly, the patient will end up a corpse. If only the right anatomical fix and technological gadget could be deployed, the corpse before them may still be alive.

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7 Bishop, 58.
8 Ibid., 21, 59.
9 Ibid., 56.
Bishop points out, however, that the dead body is unlike the living body which is dynamic, moving, changing, growing, and decreasing. This is why Bishop argues that medicine “hides death with technology,” with the result that “death is at the repressed core of medicine.”

Bishop takes his critique of medicine and, to the surprise of readers familiar with hospice and palliative care, argues that death continues to govern the medical practices in palliative care. He argues that medicine overtook the religiously inspired care popularized by Dame Saunders and transformed palliative care so that medicine could control death. In place of medical technologies and drug dosages, medicine turned to psychology, sociology, and spirituality to gain knowledge about dying and deployed the statistical sciences to determine norms for patients and families in the dying process. Bishop identifies this as biopsychosociospiritual medicine, defined as “a medicine that addresses all features of human thriving.”

His research chronicles how various disciplines from the social sciences to chaplaincy participate in medicine’s denial of death. Each discipline in a palliative care team has its own carefully constructed assessment to gauge progression and decline. These matrices apply not only to the individual patient, but also for the family and caregivers. The standardization, systemization, and professionalization that evolved into powerfully dominating forces in medicine in the twentieth century penetrated palliative care. One only needs to observe how each discrete component of an interdisciplinary professional medical team now has its own professionally licensed experts for palliative care.

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10 Ibid., 14–15.
11 Ibid., 228. See also, 227–252.
12 Physicians in the U.S. were first granted the opportunity to receive a designated specialization in hospice and palliative medicine in 2008. See The American Board of Medical Specialties News Release,
These divisions in medicine that carried over into palliative care stem in part from the fact that its founder, Cicely Saunders, worked first as a nurse, then a social worker, and finally she became a doctor. One woman possessed the expertise of all three disciplines. Combined with her Christian faith she used them to identify what had been missing in routine medicine practice—a sense of totally caring for human persons that transcends their status as patients and inclusively draws together these discrete disciplines. A key aspect of the revolution ignited by Saunders was her unique perspective on pain. She identified pain as something beyond the confines of biology and physiology; it was “total pain.” However, Bishop asserts that the Enlightenment’s preoccupation with utilitarian effectiveness so prevalent in the medicalized sciences overtook Saunders’ newfound concept of care and confined it to the rubrics of epidemiological, statistical, and evidence-based medical assessments. Thus, the physician-philosopher argues that Saunders’ inspiring vision of “total care” mutated into a medicalized control of death, and morphed into a treatment of “total pain” that is totalizing. In other words, the modern divisions in medical practice work against the originating practice of palliative care.


Nursing has a longer history in the U.S. with certification for hospice and palliative care. Its own organization, the National Board for Certification of Hospice and Palliative Nurses, credentials all levels of nursing: advanced practice registered nurse, registered nurse, licensed practical/vocational nurse, nursing assistant, and administrator.

Social workers also have a credentialing process to become a Certified or and Advanced Certified Hospice and Palliative Social Worker (ACHP-SW).

Chaplaincy has not been spared. A palliative care specialty certification is available through the Board of Chaplaincy Certification Inc. See the certification and licensing page of the Center to Advance Palliative Care, http://www.capc.org/palliative-care-professional-development/Licensing/. What is more, chaplains, though they enter their profession with support from their own particular traditions, they are trained to be open to all traditions. They are to avoid any one particular practice of faith with individual patients. Their work and ministry differs markedly from that of pastors.

13 Bishop, 255.
The problem is that for centuries care for the destitute sick and dying was an expression of *caritas* or love that flowed from religiously inspired social norms. In the twentieth century the legitimacy of activities involved in offering care, even activities like spiritual care, rituals, and chaplaincy, came under the scrutiny of scientific inquiry. Medicine’s methodologies grew to expect that activities essential and inherent to religious practices must meet measurable goals that can be empirically verified. Medicine has imposed its epistemological norms on all of the other disciplines that originally came to make palliative care such a unique experience.\(^{14}\) Any visit to the hospital today verifies that contemporary medicine operates as an interdisciplinary team, however, the physician clearly stands as the leader. With the physician serving as the team captain, medicine’s rubrics trumps the other methodologies.

Quality, measurements, and specializations, are not bad, *per se*. The problem is, efficiency was but one of two descriptors that Saunders’ used to describe her vision. The other was love. The dream that founded St. Christopher’s Hospice was that it would be a place where very sick and vulnerable individuals would encounter efficient *loving care*.\(^{15}\) The question becomes, how can medicine and Cartesian-inspired measurements calculate, document, and show a progression in love? Medicine alone has no way of gauging love.

\(^{14}\) Palliative care, as a medical specialty, operates no differently from other aspects of medicine. In order for palliative programs to continue in hospitals and healthcare systems they must operate efficiently and continually demonstrate their effectiveness. The push for efficiency and effectiveness has received the recognition and support from the National Quality Forum and the Joint Commission. Both are important as the federal government looks to these institutions to set standards to which hospitals and other healthcare institutions must adhere in order to receive reimbursement. Bishop notes that these organizations have identified eight different domains as benchmarks to assess the biopsychosocialspiritual effectiveness of palliative care for patients and their families. The domains are: the structure and processes of care; physical aspects of care; psychosocial and psychiatric aspects of care; social aspects of care; spiritual, religious, and existential aspects of care; cultural aspects of care; care of the imminently dying patient; and ethical and legal aspects of care. From such assessments, professionals can plot the road map for future, successful palliative care services. See Bishop, 266.

And yet, it is not just any type of love. The love that animated Cicely Saunders was a love she learned from her conversion to and practice of Christianity. Moreover, the Christian understanding of love, by definition, exceeds calculation. Thus, Bishop concludes his book by questioning whether Christian practices and theology can save medicine.¹⁶

I attempt to neither fully nor squarely respond to Bishop’s question. My goal is more modest, and that is to use palliative care as one very limited example of how religious faith contributes favorably to medicine. As will become clearer throughout this work, palliative care lends itself well to the argument that religious faith provides a substantial contribution to medicine, because palliative care arose from both a religious and medical ethos. By probing the intersection of medicine and religion, this work provides a counter-argument to the swift dismissal of religion, like the one seen in Fins’ work.

I aim to retrieve and discover the contribution that religious faith had on the founder of the modern hospice and palliative care movement. Moreover, I argue that practices of religious faith, particularly the sacramental-liturgical rites of the Roman Catholic tradition, can provide substantial support to the ongoing development and growth of palliative care. Both palliative care and the sacraments provide a critique of standard medical practice. Palliative care, alloyed with the Christian faith and practices, does not share the normative view in medicine that death is an ultimate enemy. More poignantly, the Christian tradition possesses a narrative of death’s redemption. I will argue that the practices of faith enacted in the sacramental-liturgical rites form the

members of the worshipping body to see death through the resurrection of Jesus Christ. This therefore, has important implications for the worshippers, be they patients with chronic or terminal illness, healthcare practitioners, administrators, or members of boards of directors.

In my work at Mercy Health, I often found myself surprised at the glacial and laborious pace of the implementation of even the smallest efforts to further palliative care within the health care system. I struggled to understand how some clinicians could be so enthusiastic while others appeared outright resistant to palliative care. Medicine, after all, is supposed to be standardized and evidenced-based, giving it some semblance of uniformity. To my eye, untrained in clinical expertise, it seemed rather convincing that even the smallest changes and practices would cohere more with palliative practices. They would not only cut waste and cost less—secondary benefits in my view—but they would better meet the needs of the patient and often more accurately reflect our values as a Catholic ministry. What is more, I saw a deep connection between palliative care and the Catholic tradition. Yet, I sensed that for most of my colleagues, the connection was much more tenuous. A desire to articulate these deep connections for the many people involved at multiple levels of Catholic healthcare ministry drives much of this research.

One primary, although not exclusively intended audience is those who work in the Catholic healthcare ministry in the U.S. Much of what is presented in these pages may also benefit other faith-based healthcare systems. This work also endeavors to further a
renewed interest among some scholars in pursuing the intersection between medicine and religion.\(^\text{17}\)

**The Practice of Faith**

An introductory word needs to be said about the practice of religious faith. In my research I find it to be an important detail regrettably overlooked, most especially in history’s retelling of the influence of the religious communities that extended care to the very ill and dying. Secular and religious historians alike have a fascination with women religious, or “the sisters,” or “the nuns.” At times these references come from a place of nostalgia. That is not meant in any way to take away from their enormous contributions made in countless societies and cultures throughout the world. Working in the context of American Catholic healthcare, every day I am conscious of the tremendous gift that women religious built and gave to the American society.\(^\text{18}\) In the last half-century or more the numbers of women religious directly participating and enacting the healing ministry at the bedside, in the executive offices, and in the boardroom have precipitously

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\(^\text{17}\) See, The Program on Medicine and Religion at the University of Chicago. Website: \url{https://pmr.uchicago.edu}; The Center for Spirituality, Theology and Health at Duke University. Website: \url{http://www.spiritualityandhealth.duke.edu}.

\(^\text{18}\) Communities of women religious have established the vast majority of Roman Catholic healthcare ministries in the U.S. and throughout the world. Throughout the work I will refer to the communities of women religious that have sponsored Catholic healthcare ministries in the U.S. This editorial judgment in no way intends to diminish the exceptional ministry of religious men. One notable example includes the Congregation of Alexian Brothers. They are a lay, apostolic Catholic Order of brothers, founded in the Middle Ages, who dedicate themselves primarily to the Roman Catholic ministry of caring for the sick, the aged, the poor, and the dying. Today in the U.S., the Alexian Brothers Health System consists of four acute care hospitals, mental health and clinical facilities, senior ministries, and other services. See, Christopher J. Kauffman, *Tamers of Death*, 2 Vols., (New York: Seabury Press, 1976–1978). The second volume has the title, *The Ministry of Healing.*
dropped. This has left leaders in Catholic healthcare to grapple with questions of Catholic identity.¹⁹

The scope of this work does not permit a full engagement of matters related to Catholic identity. It is, nevertheless, an underlying current. In the concluding section, Final Thoughts, I will suggest how this work might be used by leaders in Catholic healthcare for discernment processes, strategic planning, and discussions on Catholic identity.

I have often observed those in Catholic healthcare, as well as in secular medicine, identify the lives and ministry of women religious as exemplary. There is a sense that if only ordinary lay persons would just do the same things that the nuns did in the hospitals and at the bedside, then we would somehow get things right. As Fins did at the onset of his book, he looked at how the Irish Sisters of Charity took in the destitute sick and dying, caring for them until their last breath. If lay administrated healthcare organizations would just do the same thing, then the idea is that end-of-life care would alas, be done well. But as Bishop points out, this is not what has happened; it has not exactly been the same. Left unexamined and unarticulated is not so much what the nuns, and then Saunders did for the dying patients, but rather, who were these women? Why did they exhibit such deep concern and even love for the frail ill and dying? What did these women do with their lives away from the bedside, the administrative suite, and the boardroom that compelled them to persistently advocate for the vulnerably sick and dying?

I aver that a driving force behind the ministry of the women religious in healthcare is the fact that they cultivate a living faith. They deliberately foster community, and a unifying feature of that community is prayer. While every individual has her own unique style of prayer, women religious share the liturgical life of the church together. The liturgical life, which will be explained in the first chapter and reiterated throughout this work, centers on the paschal mystery—the life, ministry, suffering, death, and resurrection of Jesus Christ. Most basically and concretely, this means that these women participate in the celebration of the Eucharist at least every Sunday, if not daily. In so doing, they live the cycle of the paschal mystery as it unfolds over the course of an entire year. Their lives come in contact with the ministry of Jesus in Ordinary time, his incarnation in the Advent-Christmas cycle, and his suffering, death and resurrection in the Lent-Easter-Pentecost cycle. Continually informed by this rich divine narrative of life, death, and new life, these women cultivated a passion to care for those themselves experiencing the pains of suffering and death and the joys of recovery and new life. The women religious who regularly hear of the resurrection of the dead from their life of prayer can stand in sorrowful confidence at the bedside with a family painfully grieving for their father as brain aneurisms take away his life. They can remain present with that family bearing their sorrows in solidarity in a way that fundamentally differs from one who engages healthcare from a humanist or secular perspective alone.

I am making the case that it is inadequate to simply try and imitate what the nuns did in the hospitals and from their administrative positions. It is not enough to merely be present and stand in solidarity with the grieving family. What the nuns did and who they were runs deeper. If one wants to continue their ministry, then one must also feed one’s
life and soul with the same or similar spiritual food and practices. It is inadequate to say that repeating the actions the nuns performed in the hospital will yield the same ethos that they created. For example, if I aspired to be a great baseball player, I cannot just go out and swing a bat, run around the bases, and slide into home expecting to be like the MVP of the World Series. What makes a baseball player an MVP cannot be reduced to merely his observed actions within a particular game. His exceptional value as a player reflects years of hard work and practice, off-season training, carefully orchestrated coaching, a personalized diet, and more.

This dissertation argues that if we want to continue the ministry of the women religious, most particularly, their ministry to the frail ill, the elderly, the chronically sick, and the dying, and if we want to continue the legacy of modern palliative care as inspired by its founder Cicely Saunders, then we must also contend with the religious practices that stand behind the lives and ministry of these women.20 My arguments and examples herein are limited to situations pertaining to the vulnerably ill, the elderly, the chronically sick, and the dying. I do not attempt to explain how the Christian tradition may support a healthcare ministry that entails primary care practices, orthopedic replacement surgery, or research in neuroscience for example. The difference is that life-limiting, chronic, and terminal situations all share a sobering reminder of death’s imminence and human

20 James Carroll, Practicing Catholic (Boston: Houghton Mifflin Harcourt, 2009). Carroll’s vivid depiction of what it means to be a “practicing Catholic,” is worth noting. He explains, “fundamentally our religious life is a practice, like the practice of medicine. This religious practice involves practical disciplines, like acquaintance with a tradition, regular observance of rituals, and attendance, as we say, at Mass. Attending physician, attending Catholic. The sacramental life is not to be confused with subservience…. [T]he primary meaning of ‘practicing’ is that, through these disciplines, rituals, and searches, we have some prospect of getting better. This, therefore, is practice like the practice of an art or sport. That we are practicing means, above all, that we are not perfect—not in faith, hope or charity. Not in poverty, chastity, or obedience. Not in the cardinal virtues, the works of mercy or the acts of contrition. Not in peace or justice. Not in the life of prayer, which is nothing but attention to the presence of God. In all of this we are practicing, which is the only way we know to be Catholic” (Ibid., 10).
finitude. These situations lend themselves especially well to the Christian tradition’s understanding of the paschal mystery. As one begins to grow in understanding how the paschal mystery can favorably impact palliative care, then the possibilities open up to expanding the connection to other health situations. Cathleen Kaveny has prophetically challenged that an authentic meaning of health care “must not be cabined off into Catholic [end-of-life care] entirely separated from mainstream services obtained by millions of Americans every day. We must demonstrate that our treatment of the terminally ill is continuous with our vision of all health care as a work of mercy.”

Palliative care is the place to start to edge toward Kaveny’s vision.

**Author’s Context**

I write as a theologian within the Roman Catholic tradition. I studied international business before obtaining graduate degrees in Catholic theology. This combination has given me an appreciation for the complexities faced by Catholic healthcare administrators in implementing and operationalizing services such as palliative care. Besides studying theology, I also make the practice of faith a priority. That means, I regularly participate in the Sunday celebration of the Eucharist with a faith community. I have been blessed to be a part of dynamic faith communities that exhibit great care in celebrating the liturgical rites. Moreover, I have presided at the sacraments. In this work I appeal to the rites of baptism, eucharist, the anointing of the sick, and the Holy Thursday footwashing, all of which I served as a presider. When I pastored a large rural

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Catholic parish for five years, I made liturgical formation a priority, and I saw its benefits.

I recognize that many Catholics and other Christians marginally participate in regular Sunday liturgical celebrations. Much of this reality in the U.S. and across the western hemisphere is due to poor liturgical practices such as rarefied preaching, careless implantation of the revised rites, uninspiring music ministry, undeveloped liturgical spirituality, and efforts by a vocal minority to reinstate the arcane liturgical practices of the pre-Vatican II era.

One aim of this work is bring together two fundamental ministries of the church that may not always see themselves in close relation—the healing ministry of the church or healthcare, and the sacramental ministry of the church or rather, local parishes. I will return to address this connection again in Final Thoughts.

The Theological Virtues and Following Chapters

I situate the following work within the theological virtues of faith, hope, and love. Virtue ethicists place less emphasis on morally adjudicating particular actions, and instead focus on three primary questions: “Who are we?” “Who ought we to become?” and “How are we to get there?” This is not to say that the moral assessment of particular actions is unimportant. It is important. A distinguishing feature for virtue ethics is that it looks at difficult cases though the lens of the virtues more so than through a prescribed set of rules, as was common a century ago in the manualist tradition.23

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This work does not discuss the ethics of particular actions or of specific clinical procedures. I leave aside the important and often contentious topics of do not resuscitate (DNR) orders, artificial nutrition and hydration, and terminal palliative sedation. Instead, I want to take a step back to look at a broader picture. By examining the origins of ancient and modern palliative care, and doing so with an eye toward the Christian theological virtues, then future work can assess episodes like DNR and terminal palliative sedation having considered aspects of the constructive theology I have offered here.

In this work I have singled out the theological virtues of faith, hope, and love. I chose them with the intent to show how they provide essential components contrary to medicalized dying, and also because they are the virtues given to us. They are not something the Christian believer acquires or develops. They are gifts given to men and women as expressions of grace that form the human soul. Moreover, the theological virtues are grounded in the scriptures, and the tradition views them as integrally shaping Christian ethics.

In the Catholic tradition the sacraments stand as the primary means of encountering God’s gift of grace. This is why I focus on the sacramental-liturgical life of the Church in this work. I do not offer a full treatise of each of the three theological virtues, but I do show how these virtues may be communicated through the rites of the Church. By offering careful analysis of different rites of the church and their connection to palliative care, I show how the rites intend to communicate the gift of the theological virtues. In other words, because these virtues come only as gift, without availing oneself of the liturgy and sacraments, it will be difficult to more deeply experience them.

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In this work I will demonstrate how the liturgy nourishes and expresses these virtues. Given that, I argue that the liturgy holds the power to shape a program of palliative care that more clearly represents what Saunders founded and more clearly reflects a Christian anthropology. Other scholars have argued for a closer integration of liturgy and ethics, and some have extended that to bioethics. I argue that the relationship between the liturgy and ethics bears special import to palliative care.

In the chapters that follow, the first includes an introduction to liturgical theology after providing brief historical pointers that explain Bishop’s argument that death is at the center of medicine. The turn to liturgy and the sacraments will likely present unfamiliar territory for some readers, especially for those in healthcare. Liturgical theology looks less at the particular actions that we as worshippers do in the rituals, and instead considers what God does to us. The second chapter begins with an analysis on technology. I present the argument that faith serves as a critique of technology primarily because of its orientation to the transcendent. Chapter Three presents a contemporary theology of the sacraments. An examination of select components of the rites of baptism and Eucharist furthers my argument that the sacraments give Christian believers a transcendent hope, which differs from the hope promised by technology and medicine. The final chapter on love argues that palliative care grew out of a Christian understanding of love. Again, I appeal to eucharistic motifs. This time I use the metaphorical imagery of the Johannine footwashing. This rich Christian understanding of the virtue of love

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26 Sacrosanctum concilium, §59.
ought to guide the individual care offered to the vulnerable sick and dying, and moreover, it can lead to systemic changes necessary for families and society to better care for the elderly and terminally ill. I conclude by offering some final thoughts of how this work may be used by those in healthcare systems. I highlight further areas of work and improvement in healthcare, local parishes, suggestions for individual believers, those who experience chronic and terminal illness, as well as healthcare professional whether nurses, administrators, board members, or physicians.
Chapter 1 – The Medical and Christian Foundations of Palliative Care

Introduction

In this opening chapter, largely introductory in nature, I lay the foundations for my argument that the very practice of the Christian life in liturgical and sacramental life of the Church gave rise to Saunders’ vision of palliative care. Much of her motivation stemmed from modernity’s view that medical science and technology can fix ailing bodies. Yet Saunders observed how it left countless men and women to die painful and protracted deaths. To more clearly see how medicine contributes to prolonged dying, I begin by examining the historical context.

In the first of three parts, Part I will elucidate the vast differences in perspective between Fins and Bishop by way of two key sources. First, I consider Philippe Ariès’ history of dying. He examines the past four centuries and traces a transition from “tame death” to “medicalized dying.” Second, I examine a few key texts from the writings of the seventeenth-century thinker, Francis Bacon. Although his work does not speak for all of Enlightenment thinking, it does raise one key insight that runs through modernity. He believed in the power of scientific discovery to prolong human life. Remnants of his thought remain vibrantly alive and well in hospitals today. I will substantiate this subsequent point by looking more narrowly at the American healthcare context specifically through the works of the historical economist Paul Starr and anthropologist Sharon Kaufman.
Part II of this chapter defines palliative care, notes its recent growth spurt, and reviews some of the more pertinent studies in the medical literature pointing toward its efficacy and import. However, as Bishop and others have suggested, palliative care may just be another form of medicalized dying. Thus, Part III retrieves the Christian roots of palliative care. This section explores how liturgical prayer centered on the Christian narrative influenced the medical origins of care for the poor and dying. Recognizing that the connection between liturgy and caring for the vulnerable ill and dying may not immediately be self evident, this section will also explore how the particularity of the Christian liturgical tradition celebrates and focuses on the paschal mystery—the life, death, and resurrection of Christ Jesus. In other words, similar and yet different to medicine, at the center of the liturgy is the dead yet resurrected body of Christ Jesus. This represents a key difference that Christian faith offers to modernity’s quest to prolong human life. The practice of the liturgical and sacramental life of the Church forms and inculcates into the lives and minds of the worshippers the expectation that death will occur, and that it will be met by God with the resurrection of the dead. By fully and consciously engaging liturgical acts the worshipping believer is able to receive the theological virtues of faith, hope, and love—necessary virtues for a practice and experience of palliative care that avoids the entrapment of medicalized dying.

PART I – Medicine’s Drift from Religion

A team of researchers at Mercy Health, a large Catholic healthcare system, had noticed the nationwide surge of palliative care and hospice services over the past decade,
and they wondered how well equipped their physicians were to interact with terminally ill patients and their families. Specifically, they wanted to identify and measure the level of anxiety physicians felt in conversations about end-of-life care. Using a previously established physician attitude scale, their results indicated that physicians experience a moderate level of anxiety. The anxiety differed according to physician specialty, a detail that proved to be statistically significant. The highest levels of anxiety occurred among physicians in oncology, surgery, and pediatrics, and the least among primary care physicians such as family practice and internal medicine. Yet the anxiety measurement dropped for all three specialties and most others if the physician had experience in making hospice visits.

This is but one example, among countless others, that reflects an uneasiness among physicians when discussing the reality of death within their practice. Physicians, as a group, balk at the time it may require to begin discussions about incorporating


30 Alexis Coulourides Kogan, Richard Brumley, Kathleen Wilber, and Susan Enguidanos, “Physician factors that influence patient referrals to end-of-life care,” *The American Journal of Managed Care* 18, no. 11 (2012): e416-22. The authors assess physicians’ experience and comfort in discussing end-of-life care to evaluate its effect on referral patterns. They conclude that physician comfort is a modifiable factor. Thus, they argue for more education and training. Furthering palliative care via education is highly contested among physicians and medical educators. May Hua avers that simply promoting physician comfort with end-of-life discussions will not necessarily increase referrals. She critically assesses the aforementioned study noting, “the results of this trial exemplify how resistant physician behaviors may be to change.” May Hua, “Physician Characteristics Influence Referral to End-Of-Life Care,” *The Virtual Mentor* 15, no. 12 (2012): 1041-1044.

palliative services as part of a patient’s care plan. I deliberately stipulate physicians “as a group,” with a keen awareness that some physicians have garnered the skills to talk openly and lovingly to their patients about the seriousness of their chronic and terminal illnesses, and such professionals comfortably make referrals to palliative care. Many others integrate palliative practices as part of their patients’ care plan. The Mercy Study found that primary care physicians experience the least anxiety, and within this physician population, one tends to find individuals who display a greater aptitude for these frank conversations. Even when physicians conceptually concur with the philosophy and goals of palliative care, they still exhibit reticence. As will become clearer, the problem is not individual physicians per se, nor the physician’s personality, although these too could have an effect. When I refer to physicians throughout this work I am speaking broadly and from a context informed by the medical literature. I do not mean to deny the fact that some physicians betray my generalizations. What I hope will become clearer throughout Part I of this chapter is just how difficult it is for an individual physician to break out of the generalizations that will be portrayed. The same is true for a patient trying to resist aggressive therapies when disease overtakes bodily functions. The reason for these difficulties experienced by both physicians and patients rests in a medical epistemology that Bishop articulated. The problem lies with medicine itself. In the last century, the dead body became the very ground of medical knowledge, and it tacitly portrayed death as an enemy.

Philippe Ariès — The Arc from “Tame Death” to “Medicalized Death”

A millennia ago death was a natural part of life. It was ordinary; it was even expected. Families routinely experienced death and birth in their homes. Children witnessed these life events, and they often saw their elders die. By the twentieth century, a denial of death grew evermore intense in western societies. A palpable sense that one could quite possibly escape death began to take root in the social imagination. Modern advancements, if only deployed at the right time, with the right techniques, and in the right amounts, could at least deactivate death’s sting, if not defeat it altogether.

Among the histories on death, I single out the work of French historian Philippe Ariès for two reasons. First, he poignantly contrasts the differences between Medieval and modern death. In his study of death in Christian cultures over the past one thousand years, Ariès contends that a “tame death” prevailed from the time of the early Middle Ages, but several factors influenced the evolution leading to the twentieth century’s experience of “wild death.” Second, Aries’ identifies an intensified notion of wild death specific to the U.S. To best appreciate the sharp dichotomy Ariès presents, I will begin with his assessment of the tame death.

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33 Another term that will be used synonymously with “wild death” is “medicalized dying.” The explanation of wild death later in this chapter will make clear similarities between these two terms. In other words, the ubiquitous presence of medical professionals and technologies throughout the dying process is precisely what makes the experience of death since the twentieth century “wild.”
Ariès opens his voluminous work by depicting the tame death that characterized the end of life for men and women in Christian societies in the Middle Ages. Three key characteristics stand out. First, there was knowledge that one was dying. This in turn led the one dying to come to an acceptance of her own fate. There was no denial of death. A second characteristic of the tame death was common rituals. Familiar rites swirled around the deathbed. The dying person accepted an active role, if not assuming the very role of presider. For example, the dying individual would recount aspects from her life, recall the things and the people she loved. In so doing, she would also come to voice regrets from her life. She would make a profession of faith and perform a confession of sins with the priest, as well as asking for forgiveness from friends and loved ones. The rituals would conclude by the dying commending her soul to God.

Third, the tame death entailed communal accompaniment for the dying individual. Friends, loved ones, neighbors, and townsfolk kept vigil at the deathbed and participated in the common rituals. Together the rituals and the community established a sense of control in the midst of unfamiliar, unseen natural forces wreaking havoc on the dying person’s body. Even when death came suddenly, such as from an evil act or an accidental wound, these medieval traditions rendered death common, ordinary, and

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36 Ariès, *The Hour of Death*, 14–19. Conspicuously absent is an anointing or Extreme Unction. Ariès explains that this was reserved for the clergy. He notes that prayers to the Virgin Mary are also missing because the complete *Ave Maria* had not yet been formulated. One must not confuse Ariès for a theological or liturgical historian. He employs a literary methodology whereby he bases much of his social analysis from texts that were written or were popular during a particular time period. For example, his description of the tame death flows in large part from his reading of *Chanson de Roland*, the stories of the Round Table, and poems about Tristan.
meaningful.  

Ariès summarizes that “death was not a personal drama but an ordeal for the community, which was responsible for maintaining the continuity of the race.” The rituals, in which the patient and the community participated, kept death “close and familiar yet diminished and desensitized [which] is too different from our own view, in which it is so terrifying that we no longer dare say its name.” Common rituals and a communal accompaniment for the dying patient and her family represent fundamental features during the Middle Ages that quelled the primordial fight or flight reaction toward death, and it facilitated mourning.

These characteristics of the tame death point to a prevailing sense of an afterlife and a view that connects death with evil and salvation. Separation from one’s family and loved ones was seen as the work of evil and unintended by God. The prevailing sense in medieval times was that God restores and brings to life. On the last day, God will restore the fullness of life and harmony to the whole of the cosmos. Today, meaningful rituals have evaporated, a sense of the transcendent has diminished, community and friends maintain a safe distance from death, and rather than accept the imminence of our own mortality, we deploy technology to prolong life.

The tame death of the Middle Ages forms the backdrop against which Ariès dramatically contrasts the “wild death” of the twentieth century. He sees radical change

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37 Ibid., 6.
38 Ibid., 603.
39 Ibid., 28.
40 Ariès traces the shifting grounds of death, at times cumbersomely, from the Middle ages to the twentieth century. The tame death underwent a number of variations in the centuries following the Late Middle Ages. From the sixteenth to the eighteenth centuries, death became increasingly “surreptitious, violent, and savage” due in part to “the rise of rationalism, the rise of science and technology, and by faith in progress and its triumph over nature” (Ariès, The Hour of Death, 608). A significant shift occurs in the nineteenth century. The focus moves away from the individual to an other—to one’s family or loved ones. Family members worried not about their own death, but about losing a spouse, a child, or a parent. Rather than praying for one’s own self, eighteenth and nineteenth century Catholic theology’s discourse on
in the twentieth century, particularly in America.\(^{41}\) There, the experience of dying rapidly unraveled the customs of the past, and Ariès claims it is further contrasted from previous experiences of death by its novelty.\(^{42}\) The location of death changed from the home to the hospital where professionals and strangers replaced the community encircling the dying person’s bedside. Regardless of whether the patient was sick, in need of surgery, or in fact dying, the hospital became the place to encounter the physician’s care. Within the hospital, professionals urgently sought to name the patient’s illness and deploy an effective treatment. Familiar rituals and prayers accompanied by familiar faces that once distinguished tame death were displaced by strangers with endless medical specializations enacting ritual-like therapeutic interventions, diagnostic tests, cardiopulmonary resuscitation, and placing tubes in multiple bodily orifices. The movement to increasingly standardize hospitals applied a rigid template to all patients. No distinction was made between those who were dying and those who were sick or

\(^{41}\) One of the uniquely American contributions to Ariès’ understanding of medicalized dying is the funeral home. A mid-century boom in funeral homes extended the characteristics of medicalized death beyond the final respirations in the hospital ward. Funeral homes usurped the once customary rituals, created their own, and contributed to new iterations of distancing death. Ornate caskets replaced pine coffins, turning the bitter harshness of death into something beautiful. Ariès writes that funeral homes “freed the clergy, the family, and the doctor or nurses of responsibility for the deceased in the church, the home, and the hospital. The deceased was assured a place where he would continue to receive the respect that society refused him and that the churches hesitated to render him” (Ariès, *The Hour of Death*, 599). Funeral homes have created a unique social location removed from ordinary daily activities. Families no longer wake and pay their respects to the dead in the familiarity and ordinariness of the decedent’s own home or in a church. The American system that commodified care for the sick has also commodified the corporal work of mercy to bury the dead. See, Michael L Budde and Robert W. Brimlow, *Christianity Incorporated: How Big Business is Buying the Church* (Grand Rapids, Mich: Brazos, Press, 2002); Jessica Mitford wrote a seminal critique of the funeral industry in *The American Way of Death* (New York: Simon and Schuster, 1963), republished in 2000. See also my critique of how the funeral home industry dilutes the richness of Roman Catholic ritual in “The Funeral Liturgies: Preserving the Vision of the Rites,” *Pastoral Liturgy*, 4, no. 4 (July-Aug.): 2009, 5–9.  

\(^{42}\) Ariès, *The Hour of Death*, 560.
recovering. Ariès writes, “by a swift and imperceptible transition someone who was
dying came to be treated like someone recovering from major surgery.”
Death now
occurred in the remote, sterile halls of a hospital. The overpowering presence of
medicine in the dying process transformed what was one tame, the natural human
progression to death, and made it “wild.” This, Ariès names as medicalized dying.

Another aspect of the wild death, or medicalized dying, is a deafening silence.
Ariès describes the common medical practice in the late nineteenth and early twentieth
century to deny full disclosure to the patient. Such practices included physicians
deciding unilaterally to withhold information from the patient, including the patient’s
diagnosis, prognosis, the severity of the illness, and the likelihood or imminence of death.
This raises one of the limitations of Aries’ work. He exploits this foregone practice of
paternalism in medicine. His critique may be less applicable today due to the rise of the
modern secular bioethics in the mid-1970s and 1980s that championed patient
autonomy. Scientific advancements throughout the last century have provided
healthcare professionals with tools that have cured patients from diseases or at least
extended a patient’s life for many years. Ariès jarringly notes that the patient who
accepts the reality of an impending death “demoralizes the medical personnel.”

In other words, the confidence in the effectiveness of treatments has swollen to a point that has

43 Ibid., 584.
44 Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics, (New York: Oxford University Press, 1979). This first edition of Beauchamp and Childress’ work highlighted autonomy among four principles for bioethics. Subsequent editions of their work, such as the current seventh edition, include substantial discussion of virtues, although they maintain respect for autonomy as the first of four principles. For a historical perspective of the emphasis on autonomy over the past thirty-five years and a critique see, M. Therese Lysaught, “Respect: Or, How Respect for Persons Became Respect for Autonomy, Journal of Medicine and Philosophy, 29 no. 6 (2004): 665–680.
45 Ariès, “The Reversal of Death,” in Death in America, 143. In the midst of the changing pendulum swinging away from radical paternalism that withholds important and material information from the patient toward some emerging trends of disclosure to the patent, Ariès further conjectures, “The doctors probably think that a man who has been told, if he is stable, will be more wiling to undergo treatment in the hope of living to the full his last remaining days” (Ibid.)
led some to think that biological and medical science might be able to overcome death, and it has convinced many physicians that death is failure.\textsuperscript{46} Although Ariès’ point about the silence of death may no longer apply, more general remnants nevertheless remain.

Recall the study by Mercy physicians at the opening of this chapter. Many either struggle or experience notable anxiety when discussing matters of death with their patients. A young widow shared with me her experience of a doctor who informed her that her husband “was going to die.” After his death the widow bitterly recounted, “but the doctor never told me he was dying!”

I began this overview noting that Ariès sees the U.S. in a special light with regard to medicalized dying. In an early work he wrote, “It seems that the modern attitude toward death, that is to say the interdiction of death in order to preserve happiness, was born in the United States around the beginning of the twentieth century.”\textsuperscript{47} Ariès’ scholarship reflects a bifurcated reality in America. On the one hand, there is a suppression of death, the notion that it is taboo. On the other hand, there is the glamorization of death and a tendency to keep it very visible.\textsuperscript{48} When accepted, it is accepted usually as a commodity, a spectacle, or for purposes of entertainment. The point to be made is that in the wake of modernity, death is no longer tamed by ritual, the patient’s acceptance, or the presence of the community. Instead, healthcare professionals

\textsuperscript{46} Tara Tucker, “Culture of death denial: Relevant or rhetoric in medical education?” \textit{Journal of Palliative Medicine} 12, no. 12 (2009): 1105-1108. Mitsunori Miyashita., Kei Hirai, Tatsuya Morita, Makiko Sanjo, and Yosuke Uchitomi. 2008. “Barriers to Referral to Inpatient Palliative Care Units in Japan: A Qualitative Survey with Content Analysis.” \textit{Supportive Care in Cancer} 16 no. 3 (2008): 217-22. This study noted that palliative care was welcomed as it provided physicians permission to fail. It gave them some other specialty to turn to when they had to face the oncoming reality of death, so that they did not feel like they bore the responsibility for the failed medical treatments.

\textsuperscript{47} Philippe Ariès, \textit{Western Attitudes Toward Death: From the Middle Ages to the Present} (Baltimore, Johns Hopkins University Press: 1974), 94.

\textsuperscript{48} Ariès, \textit{The Hour of Death}, 596–601.
and patients alike have traded in the medieval practices for scientific medicine and technological advances in hopes that these will not merely tame death, but defeat it.

Catherine Pickstock’s scholarship sheds light on this dualism that Ariès identifies. She argues that the sense of necrophobia described by the historical accounts of modernity, is really a secret necrophilia. Pickstock interprets a key move in modernity as driving a wedge between life and death and seeking only life. She reads modernity as a search and evolution to solidify the temporal that collapses any sense of natural order or hierarchy. It created a pseudo-eternity based on “mere spatial permanence which, unlike genuine eternity, is exhaustively available to the human gaze…[and] is composed of things preservable and manageable as finite, and therefore as ‘dead.’”

Pickstock identifies a nihilistic logic at work, for in seeking only life, one loves that which can only die. In other words, modernity gave life over to death, a living death. Then, when death arrives, there is only absence. Disrupting the natural relationship between life and death “incite[s] us to attempt to prolong our lives by certain sacrificial investments.” Here, Pickstock refers to various types of security, such as legal, financial, or global. I could add any number of contemporary medical interventions that literally prolong life, sacrificing various “goods” in exchange for other perceived goods. For example, a comatose man may be kept on artificial life support so his wife can travel back from a business trip in time to see him and be with him before he dies. Some surrogate decision-makers may keep a loved one on life support indefinitely in order to continue receiving social security payments or pension checks.

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50 Ibid., 104.
51 Ibid., 105.
Geoffrey Gorer articulates something similar to the necrophilia the Pickstock identifies when he provocatively associated death with pornography. Gorer observes an increasing prudery emerging by the late nineteenth century. Just as generations past perpetuated myths that babies came from a stork or were discovered under a cabbage leaf, similarly, by the mid-twentieth century explanations of the natural process of death had been reinterpreted as a transformation like that of a butterfly or a flower. When cultural norms quarantine natural death by prudery, violent death emerges as a dysfunctional counter-expression. Gorer points to the rise of fantasy and fascination before mass audiences in gory thriller novels, war stories, gruesome science fiction, and horror comics as evidence of his point. Today, any number of highly profitable big-screen movies entail gruesome scenes of death and dismemberment. Rather than hide the pain of death on the one hand, or exploit it as entertainment or newsworthy on the other, Gorer wants to dissolve the public censorship regarding death and readmit grief, anguish, and mourning as normative aspects of the human experience and public discourse.

However one describes modernity’s treatment of death, what remains is a juxtaposition and distortion. Banishing death to the margins works only temporarily for it still comes and is ubiquitous. Glamorizing it masks the deeper human experience of grief and mourning. Ariès looked back to the time when tame death was the norm. One


may quarrel with Ariès and question his premise and methodology. It is doubtful that everyone in the early Middle Ages found a balance in death’s many emotions ranging from fear to accepting peace. Nevertheless, one strains to deny his contemporary assessment of medicalized dying. It is true that after the Second World War, the majority of Americans died in hospitals. A paradox emerged as the last century’s years ticked by, the number of Americans dying in an institutional setting climbed higher, even when most longed for the tradition of dying at home. Yet, when the reality of mortality enters the horizon of the conscious mind, the temptation is great to flee to the perceived safety of medical science. The view of medical science as the saving lifeboat finds its origins in Sir Francis Bacon’s optimism in the power of scientific progress.

**Francis Bacon — Modernity’s Search to Prolong Life**

Situated at the dawn of the early modern period, Francis Bacon (1561–1626) dispraised medicine of this day, and like a shot across the bow, he issued a formidable challenge to science that lingers to this day in medicalized dying. Bacon articulated three ends of medicine: the preservation of health, the cure of disease, and the prolongation of life. He elevated the last as “the most noble of all.” He faults the physicians of his day with these critical words:

The physicians do not seem to have recognized [the prolongation of life] as the primary part of their art, but to have confounded, ignorantly enough, with the other two. For they imagine that if diseases be repelled before they attack the body, and cured after they have attacked it, prolongation of life necessarily

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54 A century ago most deaths occurred in the home. Today, the majority of deaths occur not in the home, but in a medical institution. See, Joan M. Teno, Brian R. Clarridge, Virginia Casey, Lisa C. Welch, Terrie Wete, Renee Shield, and Vincent Mor, "Family perspectives on end-of-life care at the last place of care" *JAMA: The Journal of the American Medical Association* 291, no. 1 (2004): 88-93.

follows. But...they have not penetration to see that these two offices pertain only to diseases, and such prolongation of life is intercepted and cut short by them. But the lengthening of the thread of life itself, and the postponement for a time of that death which gradually steals on by natural dissolution and the decay of age, is a subject which no physician has handled in proportion to its dignity.  

His aggressive push to prolong life followed his novel rejection of the traditional view that men and women become “overmastered by their diseases.” The reality of disease and sickness had led them to accept the limits of human finitude. Bacon bemoaned, “pronouncing these diseases incurable gives a legal sanction as it were to neglect and inattention, and exempts ignorance from discredit.”57 Among his complaints, he observed an uncritical, unscrupulous, and general approach operative in medicine. Thus, his remedy called for greater particularity and precision. A remaining result today is an overabundance of specialized physicians and a growing dearth of primary care physicians.58

Scholars have attributed to Bacon an epic shift in moral reasoning. Men and women must no longer confine themselves to natural limits and a relationship with the Divine Creator. Instead, Bacon asserted that one can, in fact, must seek to eliminate

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56 Ibid., 485.
57 Ibid., 487. Bacon’s encouragement for innovative ways to prolong life came with admonitions, directions, and precepts. He identifies two primary means of preserving life: identity and repair. He notes that the identity of an animate thing can be preserved in the way a fly or an ant is preserved in amber or a corpse in balsam. Regarding repair, he notes that moving things can be preserved in their mechanical functioning. This later aspect is clearly seen today in the proliferation of human joint replacement. Bacon argues that an effective prolongation of life necessitates both methods (Ibid., 489–491).
suffering, pursue greater human freedom, and control nature. After all, Bacon prefaced his *Great Instauration* saying “that a way completely different from the one known before should be opened for the human intellect, and other helps devised to let the mind exert its proper authority over the nature of things.” Bacon’s writing substantiates Pickstock’s observation that modernity sought only life. As he reflected on the true ends of knowledge, he advocated pursuing it not for personal gratification, contention, convenience, or power, “but for the benefit and use of life.” Bacon sowed the seeds of denying death, and he pushed it beyond the margins of everyday life.

However, Bacon’s Puritan faith influenced his writings. He viewed science and medicine as Christian vocations because they provided a means to serve God and to advance the good of one’s neighbor, thereby strengthening humanity’s dominion over nature. Although he urged scientists to pursue their work with greater fervor and rigor, he cautioned his colleagues and followers not to lose sight of the fact that all creation follows God’s ordering. He articulates that the human intellect is prone to error, and thus “we are necessarily obliged to bring in means of bettering and perfecting the exercise and practice of the human mind and intellect.” Bacon calls upon the Lord’s help and begins his *Great Instauration* with a prayer asking that humans “stand not in the way of things divine,” that they enjoy “a clear intellect, stripped of fantasies…and wholly dedicated to divine oracles.” And lastly, he prays that “with the sciences discharged of the serpent’s poison which swells and puffs up the human soul, we do not aspire to know

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61 Ibid., 23.
62 Ibid., 17, 19.
63 Ibid., 21
what is too exalted or beyond the bounds of discretion, but cultivate the truth in charity.” This grounding figure of modernity possessed an active faith, and yet his enthusiasm for boldly new scientific progress overpowers the faith-inspired qualifications dotting his work.

I concur with theologian Allen Verhey’s assessment of Bacon. Verhey carefully refrains from ascribing all responsibility to Bacon with regards to today’s conundrum of medicalized dying. Bacon’s intellectual descendants also bear responsibility. Perhaps they did not adequately heed Bacon’s admonitions, especially his insistence that they conduct their work with a sense of responsibility to God. Yet, Verhey rightly notes how Bacon’s drive to preserve life left a lasting impact. The theologian writes, “Bacon’s project would shape the ethos of medicine no less powerfully than the [Hippocratic] oath had.” Verhey sees a direct lineage from Bacon to medicalized death via the “Baconian project,” described as:

the Promethean modern effort to eliminate human mortality and vulnerability to suffering by means of technology. It is aptly named, for its advocacy of science and technology, its celebration of human mastery over nature, and its confidence that technology could finally deliver human beings from the death and misery to which nature seems to condemn them, all find a seed in Bacon.

Verhey’s portrayal of what developed from Bacon’s idea contains three noteworthy features. First, the Baconian project endeavors to eliminate mortality, vulnerability, and suffering by means of technology. Second, this technology signals human mastery over nature. Third, confidence, bordering on arrogance, accompanies this process. In Chapter

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64 Ibid., 23.  
65 Verhey repeatedly references this aspect of Bacon’s work and accuses Bacon’s heirs of forgetting. See, Verhey, *The Christian Art of Dying*, 31, 32, 36.  
66 Ibid., 31.  
Two, I will thoroughly address technology, and these three characteristics articulated by Verhey will emerge as salient points.

The point to be made here is that these characteristics were some of the effects of the Baconian project—most of which developed after Bacon’s time and in following generations. I am not claiming that Bacon alone is responsible or even the primary root of the problem leading to medicalized dying. Many other thinkers throughout modernity contribute to an enormously large body of thought that contributes to the problematic realities of medicine in the twentieth century. No one narrative of modernity can adequately capture the challenges its poses, as well as the benefits it bestows on us today. For example, as noted earlier, the notion of patient autonomy confronted the long-standing practice of physician paternalism. The idea of the patient assuming the role of

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68 Two other Enlightenment thinkers are worth noting. René Descartes’ (1596–1650) famous *Cogito ergo sum*, asserted his doubt in all things except the fact that his mind continued to think. His intellectual program began with the move to the interior, and his own self-scrutiny landed him in his own subjective experience. In Descartes’ turn to the subject, he exalts the mind and contrasts it with extension. Descartes’ epistemological move led to a dualistic construction between the body and one’s essential self or soul. René Descartes, *Principles of Philosophy*, trans. Valentine Rodger Miller and Reese P. Miller (Dordrecht, Holland: Reidel, 1983). This rejection of the body over time becomes a rejection of the body’s nature to die. Robert Barron notes how this bifurcation relates to medicine when he writes, “Now precisely because all sense experience can be doubted, and because the body belongs to the realm of sense, this indubitable *ego* can have no necessary connection to the body. The source and ground of the characteristically modern philosophy therefore is literally disincarnate. Just as the Cartesian mind is removed from the environing tradition, so it is removed from muscle, bone, movement and blood.” A disincarnate philosophy lends itself to medical practices that view the human person as a series of replaceable parts. See, Robert Barron, *The Strangest Way: Walking the Christian Path* (Maryknoll, NY: Orbis Books, 2002), 23. Barron offers an insightful, although overly simplistic metanarrative of modernity in pp. 19-30.

Verhey laments the impact Descartes has for medicine when he writes that “Cartesian dualism gave medicine permission to see and to treat the body as manipulable matter, as *res extensa*, and it would permit nothing else!” (Verhey, *The Christian Art of Dying*, 35).

In the eighteenth century, Immanuel Kant (1724–1804) fortified modernity’s insistence on an exaggerated rationalism with his book *Religion Within the Limits of Reason Alone*, trans. Theodore M. Greene and Hoyt H. Hudson (New York: Harper, 1960). Religion’s liturgy, devotions, gospel narratives, rituals, and creeds must be limited to practical reason. Medicine carries out the effects of the Enlightenment’s emphasis on rationalism when in the twentieth century it distances itself from its religious roots. In its place, it requires that effective treatments comport with the rubrics of the scientific method. Prayer, as a possible benefit to those stricken with disease, becomes acceptable only when it can be physiologically or empirically evidenced and after scrutiny from the academy.
an active participant in medical decision making reflects an important contribution of the Enlightenment, as is the twentieth century’s championing of human rights.

By highlighting these few, albeit insufficient examples from Francis Bacon, I want to give the reader a particular example of the shifting grounds that Ariès described in sweeping generalities. Bacon’s Christian context restrained him from mistakenly embracing scientific knowledge as its own end. Empirical sciences cannot tell the scientist how to use the results, how to avoid violating human freedoms, or how and where to impose limits. Bacon’s prudent, intellectual self-restraint led him to acknowledge charity as a guide to perfect knowledge. Yet, not all of modernity’s great minds held to such limits. A virtue such as charity can guide the scientist’s work and discovery toward that which will benefit humanity and ultimately redound to the good—concepts I will address in the final chapter on love.

Ariès’ label of medicalized dying rightly names a critical problem for healthcare professionals in the twentieth century and today. The philosophical concepts, seen in seminal form in Bacon’s seventeenth century writings, reveal current epistemological forms. This brief survey of philosophical concepts provides a context in which to situate Ariès’ work, and it shows that physicians are not solely responsible for medicalized dying, even though they are its daily enablers. How they became complicit in this enterprise of medicalized dying, is also bound up in a complex confluence of factors and events. To offer a brief overview of how physicians participate in medicalized dying, I will examine two works: one from an economic-historian and one from an anthropologist. Both focus attention on the American healthcare system and shed light on how physicians participate in medicalized dying.

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The American Context

Paul Starr’s seminal work will provide an understanding of how the transformation of medicine transpired in America, and Sharon Kaufman’s anthropological work will lend a contemporary perspective that verifies the entrenched reality of medicalized dying in American hospitals.

Paul Starr’s work offers a particular historical narrative of how modernity influence the evolution of the American healthcare system and the accompanying economic factors. He argues that modernization, standardization, and professionalization coalesced in the American medical profession. These forces endowed physicians with great social, economic, and political power. Like Ariès, Starr contrasts the evolution with norms from a bygone era. In nineteenth-century America, women often cared for the sick in their homes. Physicians came from all different walks of life, and they entered the profession after a period of apprenticeship with some other skilled physician. Standardizing the rite of passage into medicine began in the late nineteenth century. Two parallel developments prompted the standardization movement. The first involved developing a common experience among medical schools. The second was the official incorporation of the American Medical Association (AMA) in 1897. Efforts to standardize medical education led to requiring a license to practice medicine, which naturally led to professionalization. The AMA developed a code of professional ethics. It directed physicians to discuss patient cases in private and then notify the patient of their professional opinion. Such a practice capitalized on the growing authority and

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power of the physician. It formed cohesiveness among doctors, and it perpetuated paternalism.

Nineteenth century advancements in scientific research impacted the modernization of medicine, which further altered the physician-patient relationship and led to patients surviving illnesses from which they previously had almost always died. Scientific breakthroughs in bacteriology resulted in vaccinations and antibiotics. As never before, surgery became a safer and viable option as it could be performed antiseptically. Other modernizing tools such as the stethoscope and radiography, allowed physicians to probe beneath the surface of the patient body to extract information that the patient could not possess on her own. Such advancements gave physicians increased knowledge that translated into confidence concerning their skills and judgments and ultimately gaining power over their patients.

Standardization and modernization affected the American experience of death. When one was sick, physicians routinely admitted patients to the hospital where an increasing range of modern technology could be deployed. By the end of the nineteenth century hospitals formed a large industry, which Starr characterizes as “medical activism, professional dominance, and an orientation to the market.” Physicians gained social and political status as a result of the professionalization movement and their ability to deploy medical technology. Patients placed great trust in physicians who increasingly possessed new technologies to treat and cure. These developments impacted end-of-life care. Increasingly, physicians pursued heroic and aggressive interventions even when the medical efficacy was ambiguous. Just as Ariès observed an American experience of death.

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71 Ibid., 148.
72 Ibid., 86-87.
medicalized dying, Starr’s account of the transformation of medicine offers concurring evidence.

Where Starr presents a macro view of the American healthcare system through the late twentieth century, anthropologist Sharon Kaufman provides vivid descriptions of highly personalized experiences in American hospitals at the beginning of the twenty-first century. There she discovers that hospitals “structure time and death within their walls, creating a new reality—death brought into life.”\textsuperscript{73} She provides compelling, and at times, ghastly narratives that demonstrate the deeply entrenched reality of medicalized dying that Ariès posited a quarter century prior.\textsuperscript{74}

Kaufman’s research, more than four centuries after Bacon, witnesses to an undying drive in medical science to prolong life. Yet, she notices that hospital procedures reach a point where the effectiveness of medicine stalls. The medical options begin to dry up in what she describes as a gray zone of indistinction and a threshold between life and death in which hospitals manage patients in one of three ways. They can employ medicine to manipulate the timing of death by staving it off, arranging for a “good” death, or hovering at the threshold. These three pathways represent the systemic procedures for moving things along.\textsuperscript{75} Bureaucracy, politics, and the rhetoric of the patient’s condition all impact the pathway toward the patient’s death. She writes that the gray zone “is the

\textsuperscript{73} Sharon Kaufman, \textit{And A Time To Die: How American Hospitals Shape the End of Life}, (Chicago: University of Chicago Press, 2005) 1.

\textsuperscript{74} Aries, \textit{The Hour of Death}, 588. Regarding medicalized dying he wrote, “Death no longer belongs to the dying man, who is first irresponsible, later unconscious, nor to the family, who are convinced of their inadequacy. Death is regulated and organized by bureaucrats whose competence and humanity cannot prevent them from treating death as their ‘thing,’ a thing that must bother them as little as possible in the general interest.”

\textsuperscript{75} Kaufman, \textit{And A Time To Die}, 95-202. “Pathway,” is a common term used in the clinical setting. It refers to an administrative or managerial workflow method intended to organize, evaluate, and limit variations in patient care. It seeks, in part, to ensure that patients with the same diagnosis receive the same treatments. See, Taber’s Online Medical Dictionary, \url{http://www.tabers.com/tabersonline/view/Tabers-Dictionary/734579/all/pathway?q=pathway#4}. Accessed, May 14, 2014.
moral and biotechnical frontier of contemporary hospital culture, and its existence
demands that everyone in the system deliberate the value of life itself in its most
vulnerable forms.”

Everyone in the hospital setting must contend with some
understanding of suffering, dignity, and quality of life. Both the patient’s interpretation
of these concepts as well as those of the healthcare practitioners frame the considerations
and negotiations regarding dying and the timing of death.

Even when the Baconian question to prolong life capitulates, still the medical discipline arranges for a “good”
death but absent of the social, cultural, and religiously-inspired rituals that Ariès described in that tame death.

Most concerning to Kauffman is how “medical science and practice in American society manufacture[s] the natural today.”

She fears that the American hospital setting is shifting how society perceives human nature. She writes, “When the vision of an autonomous nature is exploded, as happens in the hospital when death enters the realm of clinical-bureaucratic control, an important ground for anchoring ideas of the moral is removed.”

The Baconian project is reaching an apex, arguably an extreme expression, as medical practices manipulate the natural limits imposed by human finitude. They offer engineered conditions that present new and foreign choices to patients.

Nature, Kaufman writes, “has been replaced by the right and the obligation to choose, by the specter of litigation, the desire for control, the pressure of time, the qualification of

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76 Kaufman, And A Time To Die, 318.
77 Ibid., 271-2.
78 Ibid., 324. Emphasis original to author.
79 Ibid., 325.
80 Kaufman emphasizes the desire patients and their families express for choices at the end of life. Many times the options they want to pursue are unreasonable or would require clinicians to practice below a professionally established standard of care. Kaufman notes that the medical practices within the hospital constrain the range of options that a patient can pursue.
disease and *dying*, and by debates about futility."\(^{81}\) Kauffman ends with a hesitant hope that change is possible, but not without first recognizing how medicalized dying has become *naturalized*.

One emerging clinical pathway that seeks to address and avoid the gray zone is palliative care. As Kaufman followed twenty-seven patients over the two-year span of her research, she witnessed conversations regarding palliative care and observed healthcare professionals’ attitudes. She found them exhibiting a “fluid understanding” of it. Many physicians from differing medical specialties believed that their discrete treatments already provided sufficient comfort to patients, and they tended to question exactly what palliative care is. Kaufman concluded that it evades adequate definition in the abstract. More practically, “it is defined by physicians on the ground, in relation to kinds and degrees of treatment… Immediate aggressive intervention is sometimes rationalized as the most efficient way for the patient to receive palliation at some later point.”\(^{82}\) To systemically sustain palliative care as a clinical pathway that changes the reality of medicalized dying, it is important to understand how palliative care emerged and to define what it entails.

**Part II – Palliative Care and Its Growth**

**Palliative Care Defined**

For the purposes of this current work, I use a definition of palliative care offered by Ascension Health, the largest Catholic and the largest nonprofit health system in the

\(^{81}\) Ibid., 326. Emphasis original to author.  
\(^{82}\) Ibid., 39.
U.S. Their definition incorporates concepts borrowed from leading national and international authorities on health such as the World Health Organization, the National Consensus Project for Quality Palliative Care, and the Supportive Care Coalition.

Ascension Health describes palliative care as follows:

Palliative care is an interdisciplinary health care approach which focuses on improving quality of life for persons living with or affected by chronic or life-threatening conditions, through the prevention, assessment and relief of pain and other physical, psychosocial and spiritual symptoms, from the time of diagnosis throughout the process of living and dying. Such excellent care will be provided according to need either concurrently with life-prolonging treatment or as the main focus of care, respecting the values and goals of individuals, their families and other loved ones. It will assist them to live fully in community, optimize function, facilitate goals and decision-making, provide opportunities for personal growth and healing, and will support families, other survivors and communities in their bereavement.

A visual representation of the Ascension paradigm is offered here:

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83 See the Ascension Health Website:
Three features of the definition merit attention. First, palliative care aims to support those persons who live and suffer with life-threatening illness as well as those with *chronic* illnesses, and this care can occur *concurrently* with other treatments, including curative treatments. This marks a significant difference between palliative care and the practice of hospice in the U.S. Unlike the former, legal parameters and insurance regulations confine hospice to a physician’s clinical determination that a patient is *terminally ill*, meaning, “the individual has a medical prognosis that the individual's life expectancy is 6 months or less.” One patient is either “in hospice” or not; palliative care does not follow this either/or distinction. As the graphic illustrates, palliative care entails a broader designation within which hospice services can be engaged. Cancer patients, for example, do not have to pursue an exclusive pathway of either comfort measure only

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84 U.S. Social Security Act, Section §1861, [42 U.S.C. 1395 dd (3)]a. In the U.S. hospice is a guaranteed social benefit reimbursed by Medicare and most all other insurance plans. One other clarification of terms is needed between palliative medicine and palliative care. If the adjectives are removed, what is left to consider is the difference between medicine and care. The expansive developments in treatment options in the twentieth century led the medical community evermore to equate care with the dispensation of medication. My observation has been that the term palliative medicine is generally associated with and used by physicians or those in healthcare professions who normally are responsible for administering medication to patients and those who possess the clinical authority to determine care plans. Saunders herself preferred the term palliative medicine to that of palliative care. She criticized her fellow physicians who say that “There is nothing more to be done.” She explained how even in the last phases of life, the same detailed approach of a doctor’s time and expertise is needed. See, her article in the inaugural edition of Palliative Medicine, “What’s in a Name?” Vol. 1:1, 57–61, 1987. Nevertheless, others contend that good patient care extends beyond medicine. It must entail *care*—a concept larger than the medicine itself. Many disciplines offer important roles necessary for compassionate and quality care. Even when medicine may not be able to ameliorate or cure a patient’s condition, the Catholic vision for healthcare ministry exhorts a duty to care. See the United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Fifth Edition, 2009. Hereafter cited as Ethical and Religious Directives, or ERD. See especially the Introduction to Part 5 “Issues in Care for the Dying.”

Throughout this work, I will refer to palliative care since that is the most widely used term within the practice in hospitals and healthcare systems.

or radiation treatments. They may vacillate between the two depending upon their condition and the goals of care.

Palliative care strives to maximize symptom management for patients who are living longer with illnesses that cannot be cured. Many in the palliative care field refer to a whole continuum of care—meaning they attend to the patient’s needs and symptoms from the time of a diagnosis and, as the definition stated, “throughout the process of living and dying.”

Second, Ascension Health’s definition of palliative care emphasizes the needs and wishes of the individual patient and her own goals of care. Palliative care teams take significant amounts of time, notably far more than most all other medical disciplines, to talk with and listen to the patient and to understand her worldview. They gain a sense of her values so that the medical care can be directed toward assisting her to realize her goals and to live as fully as she can with the illness she bears. This contrasts with the Baconian presupposition that medicine must pursue the prolongation of life. In this palliative care model, the physician alone does not determine the ultimate course of action. The physician may be one of a number of people providing pertinent information to the patient who, in collaboration with others, discerns the course of treatment options.

The final feature worth noting in Ascension’s definition of palliative care entails the attention given to the role of the community and the patient’s loved ones. Palliative care strives to optimize the patient’s functions so that she may interact as fully as she is able with her family and the wider community. This important detail of palliative care echoes a similar component of the tame death. Ariès lamented the loss of a tame death and repeatedly drew attention to the actions that distanced death from the community and
loved ones. Our modern understanding of palliative care recognizes that those who bear the weight of the illness are not simply the patient; rather, support is also needed for the family and loved ones. Furthermore, care is not limited to just the natural trajectory of the disease itself. Ascension’s definition sensitively honors the importance of mourning, another feature of Ariès’ tame death, as it offers care to the survivors and the community during the time of bereavement.

**Expansion and Models of Palliative Care**

The growth of non-hospice palliative care programs has witnessed a steady increase over the last ten years. In 2008, over half of all US hospitals had a palliative care program and more than 75% of large hospitals identified as having more than 300 beds reported a hospital-based palliative care program. Catholic healthcare systems count themselves among those striving to cultivate and strengthen palliative care programs. Together, twenty-two Catholic healthcare organizations with over 450 hospitals, 300 long-term care facilities, numerous clinics and home healthcare services in 45 states comprise the Supportive Care Coalition, whose mission endeavors to advance excellence in palliative care. Many Catholic healthcare systems have initiated impressively large-scale programs integrating palliative care across their facilities. The actual delivery of palliative care services looks different across various healthcare

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87 See the Supportive Care Coalition’s website: [http://supportivecarecoalition.org](http://supportivecarecoalition.org).

organizations and even within a particular health system.\textsuperscript{89} They aim to make it a part of standardized care not only within their own systems, but also within the structures of the nation’s healthcare delivery. Integrating palliative care in national healthcare practices is important because currently palliative care practitioners struggle to receive reimbursement for much of their work.\textsuperscript{90} In the final chapter on \textit{caritas}, I will address how systemic and policy changes may result from a theological understanding of palliative care.

Healthcare systems have begun promoting palliative care programs in the last two decades because healthcare practitioners and administrators had repeatedly seen the deleterious effects of medicalized dying. Medicine aimed to prolong life, but by the mid-twentieth century, healthcare professionals and patients alike saw that the life medicine prolonged for the frail elderly and the chronically and terminally ill was a life often hooked up to ventilators, dialysis machines, pacemakers, intravenous needles and tubes administering powerful antibiotics or nearly deadly chemotherapies. Palliative care, which allowed the patient the freedom to forego aggressive clinical therapies, provided needed support to the patient by managing symptoms, controlling pain, pursuing spiritual

\textsuperscript{89} By the 1970s, shortly after the first modern hospice house opened, four models of care for the vulnerable and dying emerged. The first entails a separate hospice house where care directly focuses on the dying patient. Second, a Palliative Care Unit or a Continuing Care Unit situated within an exiting hospital provides focused pain and symptom management for very sick patients. The care in these units does not primarily aim to be curative; rather, the overriding goal is management of symptoms. Home Care is a third model. This involves the healthcare professional going to an individual patient’s home, the very location where many people desire to die. Lastly, there are Hospital Support Teams that function as a consulting service, called by other healthcare professionals to see a patient. Through this consult the patient could learn about medical options, including less aggressive ones that, nevertheless, meet medical standards of care. To one degree or another, these four models remain in practice today.

\textsuperscript{90} For example, see the advocacy priorities for 2011-2012 outlined by Catholic Health Initiatives. Their first item is “Access and Coverage for All,” under which they include the need to enhance access to palliative care for persons facing life-threatening illnesses. \url{http://www.catholichealthinit.org/body.cfm?id=39086}, accessed, Nov. 11, 2011. The Supportive Care Coalition, describes that among its roles, it advocates for social policy changes. See its homepage: \url{http://www.supportivecarecoalition.org/}, accessed, Nov. 11, 2011.
resources, and tending to the needs and experiences of the patient’s loved ones as well. Those who practiced palliative care had a hunch that it provided better care to patients than the aggressive therapies and invasive procedures commonly experienced in medicalized dying. Yet healthcare administrators and physician teams, trained in the scientific method, wanted evidence beyond a hunch and mere patient anecdotes. The gold standard is a randomized trial, and Jennifer Temel and her colleagues delivered evidence of the benefits of palliative care in 2010.

The Lung Cancer Study

The therapies offered by palliative care teams seemed to equipped patients with the resources necessary to navigate the obstacles imposed by medicalized dying.\(^{91}\) Until Jennifer Temel and her colleagues published their study of lung cancer patients in 2010, researchers, concerned that dying in U.S. healthcare institutions had in fact become too medicalized, sought to identify those things that patients perceived would contribute to a “good death.” Results revealed five domains important at the end of life: 1) receiving pain and symptom control; 2) avoiding inappropriate prolongation of the dying process; 3) achieving a sense of control; 4) relieving burdens on family; 5) strengthening relationships with loved ones. These findings indicate a mix of elements from both medicalized dying and Ariès’ tame death. Medicalized dying seeks to relieve the burdens on the family and others by bringing all aspects of care under the domain of medicine. Strengthening relationships with loved ones was a hallmark of the tame death. See, Peter A. Singer, Douglas K. Martin, Merrijoy Kelner, “Quality End-of-Life Care: Patients’ Perspectives,” *JAMA: The Journal of the American Medical Association* 281, no. 2 (1999): 163-168.

Singer et al documented patients’ wishes, and other researchers have documented the actual experiences of those who died. Those researchers concluded that patients dying in institutions have a higher likelihood of experiencing unmet needs for symptom control, physician communication, emotional support and being treated with respect in their dying days. The family members of those who died at home with hospice were more likely to report an excellent overall assessment of the care (70%). See, Joan M. Teno, Brian R. Clarridge, Virginia Casey, Lisa C. Welch, Terrie Wette, Renee Shield, Vincent Mor, “Family Perspectives on End-of-Life Care at the Last Place of Care,” *JAMA: The Journal of the American Medical Association* 291, no. 1 (2004): 88-93. Teno also conducted a follow-up study examining the experiences of families after a loved one died in a high-intensity hospital setting. Her findings revealed that family members perceived lower quality for emotional support, shared decision-making, information about what they could expect, and respectful treatment. These findings echo Sharon Kaufman’s observations that American hospitals tend to be undesirable places to die. See, Joan M. Teno, Vincent Mor, Nicholas Ward, Jason Roy, Brian Clarridge, John E. Wennberg, and Elliott S. Fisher, “Bereaved Family Member Perceptions of Quality of End-of-Life Care in US Regions with High and Low Usage of Intensive Care Unit Care,” *Journal of the American Geriatrics Society* 53, no. 11 (2005): 1905-1911.

\(^{91}\) Researchers, concerned that dying in U.S. healthcare institutions had in fact become too medicalized, sought to identify those things that patients perceived would contribute to a “good death.” Results revealed five domains important at the end of life: 1) receiving pain and symptom control; 2) avoiding inappropriate prolongation of the dying process; 3) achieving a sense of control; 4) relieving burdens on family; 5) strengthening relationships with loved ones. These findings indicate a mix of elements from both medicalized dying and Ariès’ tame death. Medicalized dying seeks to relieve the burdens on the family and others by bringing all aspects of care under the domain of medicine. Strengthening relationships with loved ones was a hallmark of the tame death. See, Peter A. Singer, Douglas K. Martin, Merrijoy Kelner, “Quality End-of-Life Care: Patients’ Perspectives,” *JAMA: The Journal of the American Medical Association* 281, no. 2 (1999): 163-168.
no one had provided an explanation as to how or why this was so. Temel et al selected patients with metastatic non-small-cell lung cancer because the treatment is intense; patients experience substantial symptom burden, and they may receive aggressive care at the very end of life. Moreover, metastatic non-small-cell lung cancer is the leading cause of death from cancer worldwide. It is a debilitating disease with highly burdensome symptoms, a poor quality of life, and a prognosis of death within a year. In their study the researchers randomly assigned patients newly diagnosed with this type of cancer to one of two groups. One group of patients received the standard oncologic care only. The other group received palliative care integrated with the standard oncologic care. The researchers measured patient quality of life and mood at baseline and at twelve weeks. Different from previous studies, this one availed patients of palliative care beginning at the time of diagnosis or within a few weeks thereof, thereby differentiating it from hospice care.

The results provided what palliative care advocates had long surmised. The patient group receiving palliative care had a better quality of life and fewer depressive symptoms than those in the standard care group. The patients with early palliative care received less aggressive end-of-life care, and most surprisingly of all, they lived on average nearly three months longer than patients who received standard care—a significant difference by clinical standards. Temel et al tacitly suggest to physicians that their acceptance of a cancer patient’s impending death counter-intuitively leads to better patient care, decreased anxiety, and a prolongation of life. The authors write that, “with earlier referral to a hospice program, patients may receive care that results in better

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management of symptoms, leading to stabilization of their condition and prolonged survival."93 Furthermore, the authors concluded that palliative care can alter the use of health care services at the end of life. In other words, such patients experience a less-medicalized death, at least to the degree that they utilize fewer aggressive medical interventions.

To the eyes of many, this watershed study confirmed palliative care as the mechanism to help patients escape medicalized dying. Patients received excellent pain and symptom control, and they avoided medical technologies that had a penchant for bringing death into life. Like the tame death where the patient presided over the rites, these patients maintained a large degree of control over the medical procedures and rituals. Their families felt support from the palliative care team, and the permission patients received to forego exhausting radiation and chemotherapy appointments gave them time to spend with their families and strengthen relationships. In this sense then, palliative care seems to be, or at least holds the potential to be a contemporary version of tame death.

It is tempting to conclude that a panacea for medicalized dying has appeared, but obstacles remain. First, the researchers conducted the study with patients who had a very particular type of cancer known to always be fatal. How this clinical pathway can be adapted to address the needs of non-cancerous and chronic conditions such as chronic obstructive pulmonary disease or multiple sclerosis remains to be seen. Second, it has yet to be repeated by other researchers in different locations. Lastly, perhaps a greater shortcoming of this study is the fact that among its two key findings, it lauded the benefit and worthiness of palliative care based on its ability to prolong life—the very criterion

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93 Temel, et al, "Early Palliative Care," 739.
Francis Bacon set out for medicine more than four centuries ago. The very natural human experience of dying is directed almost exclusively by medicine, and determinations as to what is normal and what ought to happen in that process is likewise determined on the grounds of scientific methodologies. Because of this, scholars like Jeffrey Bishop and Sharon Kaufman wonder whether palliative care is simply a new and subversive form of medicalized dying. Bishop in particular makes this very argument. When palliative care is seen exclusively under the domain of medicine and its success and worth judged against scientific standards—quality of life and quantity of weeks or months lived—then it becomes vulnerable to the burdens of medicalized dying. If in fact palliative care is not another instantiation of medicalized dying, that it is actually something else and Bishop’s argument is mistaken or flawed, then it is the task of those who believe this to evidence their claims. For my part, I endeavor to provide a constructive theology to support Bishop’s observations that the practices of the Christian life offer something important, if not essential, to palliative care. What prevents medicalized dying is not simply a new medical methodology. Rather, preventing medicalized dying entails something from outside medicine itself. Dame Saunders found that the practice of the Christian faith assisted her efforts to confront the total pain associated with medicalized dying.
Palliative Care—More than Medicine

Medical history names Dame Cicely Saunders (1918–2005) as the founding pioneer of modern hospice and palliative care. As a young woman during the outbreak of the Second World War, Saunders set out to become a nurse. She was happy for the first time in her life after having experienced a troubled childhood of grief and rejection. Unfortunately, the demands of nursing exacerbated back pains from which she suffered as a teenager. Knowing she had to stay close to her patients, Saunders became an almoner, the equivalent of a medical social worker.

While managing cases on a cancer ward at St. Thomas’ hospital, Saunders met David Tasma. David was a forty-year-old agnostic, Polish Jew, who fled Warsaw before the uprising. He had lost his mother at a young age, had limited formal education, and always felt like an outsider. He never integrated into English society, and Saunders met him after his diagnosis of inoperable cancer. Saunders was the only consistent visitor in his last two months of life in 1947. Their discussions intimately probed ideas to address the needs of patients in David’s situation. Saunders came to see the dreadful despair of so many patients who felt alone, isolated, and rejected at the end of life. Their experience included differing types of deep pain and unmet needs. Saunders saw that medicine alone could not provide the remedy. She described David’s experience and others like his, as “total pain,” which is not constrained to the physical, but rather encompassing emotional, social, and spiritual aspects, the suffering of the whole person and part of a
network of relationships.\textsuperscript{94} She believed that total pain required “total care.” If all the many needs could be “met in a context of real concern for the individual person, it might become possible to die peacefully, even happily.”\textsuperscript{95} As Saunders shared in David’s life, suffering, and death, a dream sparked.\textsuperscript{96}

Saunders heeded the advice of a physician mentor who suggested that if she earnestly wanted to address the pain experienced by the dying, she needed to study medicine. So she did. While in medical school, she received a research fellowship and arranged to work at St. Joseph’s Hospice in Hackney. The Irish Sisters of Charity, a Roman Catholic order of women religious ran this home for the dying. There, Saunders experimented with and implemented a system for administering pain medications known as “regular giving.” She first learned of this technique as an almoner at St. Luke’s. Physicians there had been experimenting with this new dosing technique since the mid-1930s. The protocol entailed giving pain medications at regular intervals before the pain recurred. In her role as researcher Saunders kept detailed records, and in addition to the dosing procedures, she instituted standards for patient notes, drug charts, ward report books, and changes in visiting hours that gave greater freedoms to the patients and their families.

Saunders observed twentieth-century medicine trending toward providing answers and cures. Without a cure to offer, doctors felt they had failed. Saunders noted that, “Doctors did not consider it their job to ease the process of dying beyond prescribing

\textsuperscript{95} Du Boulay, \textit{Cicely Saunders}, 36.
\textsuperscript{96} Ibid., 37.
pain-killing drugs; as far as possible, they avoided dying patients, embarrassed by what they saw as failure.” When physicians could not offer a cure, patients were virtually abandoned. Two studies of English hospitals emerged in the early 1960s that described deplorable conditions. One study referred to “human warehouses” and “hospital slums.” Saunders identified a gap in the healthcare system created by medicalized dying. It left the frail elderly and the terminally ill in the lurch, and she experienced a calling to address it. She wanted to establish St. Christopher’s Hospice, a home where the aged and the terminally ill could “live until they die.”

St. Christopher’s Hospice opened in London in 1967. Contrary to contemporary American experiences of hospice, St. Christopher’s was more than home for the dying. While Saunders gave special welcome to individuals in the end stages of cancer and other diseases, one wing was dedicated to badly disabled patients with chronic illnesses. Another annex provided single rooms for the elderly. Together, the residents and staff formed a community of loving concern and care. Saunders’ vision and success soon spread far beyond England, and she received invitations to give lectures across the world and help other organizations establish similar institutions.

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97 Ibid., 53.
98 Ibid., 57. The author cites a 1961 report to the Birmingham Regional Hospital Board by J.H. Sheldon. The author also notes that Saunders was aware of the disgraceful descriptions contained in John Hinton, Dying, 2nd ed., (Baltimore: Penguin Books, 1972). Furthermore influencing Saunders was a 1952 survey conducted by the Joint National Cancer Survey Committee, part of the Queen’s Institute of District Nursing and the Marie Curie Memorial Foundation. The surveyors visited over 7,000 patients who remained in their own homes with terminal cancer diagnosis. The first of their eight conclusions noted the obvious and considerable hardship for families and advocated for residential homes, not solely for cancer patients but also for other patients as well. This study was followed by a second conducted by Brigadier Glyn Hughes that exposed a serious gap in the National Health services regarding the care for the chronically bed-ridden who did not need immediate hospitalization, but whose conditions required prolonged nursing care over a period of months to years (Du Boulay, Cicely Saunders, 56–58).
Saunders’ Christian Vocation

The influence of Christian faith and practice on the founding of the modern hospice movement by Cicely Saunders receives scarcely a footnote in the clinical retelling of the story, evidenced in the example of Dr. Joseph Fins’ book presented at the onset of this work. Yet, the Christian faith is the essential detail that differentiated the total care that Saunders provided to the residents at St. Christopher’s Hospice. When Saunders was in her late twenties working in the St. Thomas’ cancer ward as a social worker, she became a Christian. She lived with five other women, and together they studied the Bible every day. A recurring question remained for Saunders as to what she should do to say thank you and to serve God. Her response came during the time she cared for David Tasma.

Saunders and Tasma engaged in a series of conversations in his final weeks of life. Their nearly two-dozen conversations in the last weeks of his life included “discussions about how people might be cared for when they are dying.” Yet, their conversations were not merely clinical in nature; they also discussed religion. David recounted to Saunders how in his youth he argued with his Rabbi grandfather. Over the course of the visits, the two explored topics that included the Gospels, the Lord, Judaism, Isaiah, and peace. Through their encounters, “it was overwhelmingly borne in on Cicely how acute the need was, how dreadful the despair of so many people. Gradually an idea began to take shape, that perhaps she, Cicely Saunders, could do something about it…. [B]eing so close to someone who was dying showed her the need for a rounded care for

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99 Ibid., 35.
100 Ibid., 34.
the terminally ill that was totally lacking.”

Before dying, David shared with the ward sister that he had made peace with God. He left what little he had to Saunders saying, “I’ll be a window in your home.”

Saunders knew she had to do something for the many people dying lonely, painfully agonizing deaths.

Following David’s death, Saunders knew she had to establish a home for the very ill and dying, and she knew that she would need help, including prayer. She enlisted the prayers of three residents at St. Joseph’s whom she befriended: a Catholic, an Anglican, and a Jew. These “founding patients” prayed regularly for the success of Saunders’ plans.

Even before breaking ground to construct St. Christopher’s, Saunders’ initial draft proposals undeniably indicated that it was both a religious and medical organization.

Once it opened, Saunders began receiving inquiries from around the world to speak about caring for patients with intractable pain and terminal illnesses, but in her presentations “she was far more concerned with being medically sound, with making sure people did not see hospice work as a soft option, but as the tough clinical challenge that it is.”

Cognizant of the Cartesian-influenced skeptical mind of medical scientists, Saunders did not initially elaborate on the spiritual side of her vision. We can only speculate as to her rationale for presenting only the clinical protocols she helped to popularize to address intractable pain. It is not ours to debate in this work whether her strategy was, in retrospect, regrettable. The important piece for this project is the clarity that faith played in her founding vision. From the time of her initial plans and all throughout her life,

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101 Ibid., 36.
102 Ibid., 36.
103 Ibid., 54.
104 Ibid., 120–134.
105 Ibid., 182–183.
Saunders insisted that St. Christopher’s would be open to people of all religious affiliations and those with none. Yet in her draft proposals she hoped to render higher and more valuable service to our patients in their spiritual and mental than in their physical wants. These will, all the same, go hand in hand, for faith in God is made infinitely easier by the faith in man which is created by the touch of kindness and the relief of pain and discomfort…. Though we cannot heal, there is a great deal that can be done to relieve the suffering of every dying person.  

One of her advisors observed that “Cicely was not just doing a medical work as a Christian, nor was she just a Christian who happened to be a doctor; [the advisor] realized that Cicely had both a medical and a spiritual vision, that the two were inextricably mingled and that it was good that this should be so.” From the onset, faith—and in particular the Christian faith—provided the motivating ethos for the vision of loving care, which Saunders knew medicine alone could not provide to every patient.

On the one hand, Saunders’ work was unique in the sense that as a Protestant laywoman she took a vision that had been inspired by her experience and practice of the Christian faith, and she wove it into an effective clinical practice in such a way that her colleagues in medicine not only understood, but desired to emulate. St. Christopher’s was unique not simply because it was a hospice house, but also because of its dedication to research and teaching, in addition to its commitment to caring for the very elderly and the chronically and terminally ill. On the other hand, Saunders’ vision was not novel, certainly not within the horizon of Christian history.

Christian Communities Practicing Medicine

106 Ibid., 63.
107 Ibid., 68.
Saunders’ calling and dream to establish St. Christopher’s Hospice awakened a twentieth-century reinterpretation of Christianity’s centuries-long ministry of care to the destitute sick and dying. In a lecture given to nurses at Yale in 1986, Saunders described the ancient roots of hospice. Western medicine forever changed when early Christian monasteries opened their doors and provided hospitality to the sick and to the poor. The monastic infirmaries served as a precursor to hospitals, the first of which Basil established outside Caesarea. It contained designated areas for the poor, the homeless and strangers, orphans and foundlings, lepers, the aged and infirm, and the sick.

Gary Ferngren emphasizes the uniqueness of the hospitals established by fourth-century Christian believers. Different from the Roman infirmaries, the Christian hospitals that emerged in the mid-fourth century, “owed much to the church’s long experience in caring for the ill and to its careful attention to the organization of charity within a congregation-centered pattern. Both were legacies of the first three centuries of Christianity, and without them the immediate success of the hospital…would have been impossible.” Grounded in a commitment to care for the poor and the ill, in many instances, palliative care of the sick remained the only option. Christians gained their strength and calling to care from the gospel narratives, among them the story of the Good Samaritan saving the man left for dead along the roadside (Luke 10:25–37). This story, among many others, challenged the social norms. Ferngren elucidates how the strongly democratic and self-help nature of the Greco-Roman culture did not possess a public...

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111 Ibid., 125.
112 Ibid., 126
113 Ibid., 130.
obligation to care for the sick and dying. Local bishops, like Basil, who played important roles in establishing the first hospitals, delivered homilies to catechumens and neophytes stressing that their lives ought to manifest a notable difference in society. Ferngren assesses that the Christian community provided the ideological framework for a programmatic way of caring for the sick, both within their own community and extending it to all persons as mandated by the Gospels. Thus, just as Saunders’ vision contained her express desire to welcome Christians and non-believers, so too did the early Christian communities offer hospitality and care to anyone in need.

A Christian ministry of care to the destitute sick chronicled in the New Testament and brought to life in a new way by early Christian monastic communities, continued through the centuries. Communities of religious men and women throughout Europe established hospitals and provided the personnel and the facilities to care for the sick. American Catholic historian, Christopher Kauffman, describes how religious, usually women, accompanied European emigrants who settled in the U.S. and established an impressive healthcare ministry. Their zeal for missionary activity moved them beyond their homelands and beyond the convent walls where they nurtured new ministries in education and healthcare. Where previously they knelt in the chapel, they now found a new place for sacred prayer at a patient’s bedside where they saw God’s saving and merciful work. The very act of nursing gave these women religious meaning. Their nursing informed their prayer and their prayer informed their care. In the chapel, they

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prayed under the agonizing gaze of Jesus suffering on the cross. The centrality of the life of Jesus in their rituals and prayers formed these women to see the sufferings of their patients as similar to the sufferings of Jesus. Knowing that Jesus’ suffering ends in his resurrection, they could maintain a hope that their patients’ sufferings would not endure. Thus, they brought the names, the lives, and the faces of their patients to their prayer.\(^\text{117}\)

From their private prayer and their experience of partaking in the Eucharist, they encountered the faithful presence of God who assured them of mercy and love. As they returned to the bedside, they brought the strength of God’s fidelity. They possessed a unique ability to remain with those who were suffering and dying. This was evermore apparent in times of disaster, epidemic, and war.\(^\text{118}\)

In the faces of the sick, they saw the face of Christ, and to the sick, the religious represented the loving and merciful presence of Christ sharing their suffering, despair, loneliness, and pain at the bedside.

**Christian Worship and Human Nature**

For over two millennia, two central Christian concepts have sustained the ministry enacted primarily by religious communities that furthers the Gospel mandate of care for the vulnerable, sick, and poor (Matt 10:8; Mark 6:13; Luke 9:1–2;). First, the Christian view of the human person entails a seamless relationship between *cura corporis* and *cura animae*, or care of the body and care of the soul. The Christian tradition understands the

\(^{117}\) Kauffman describes a dialect between the cloister and the ward especially as technological advancements substantially altered the more traditional forms of care (Ibid., 190–191). Elsewhere he notes that in at least some instances, the expectation of a practice of faith also applied to lay trustees, administrators and department heads as the sisters increasingly relied more on outside expertise (Ibid., 152–153).

\(^{118}\) Ibid., 82–95. Kauffman notes that in contrast to other nurses, physicians tending to casualties of the U.S. Civil War preferred women religious. See also the details of Sisters of Mercy at the time of the Crimean War (Ibid., 25–26); and the response to nineteenth-century cholera outbreak in the U.S. (Ibid., 50–63).
human person as comprising of body and soul, the earthly and the divine. This represents a cornerstone of Christian anthropology.\(^{119}\)

St. Thomas Aquinas describes the soul as animating the body and the first principle of life.\(^{120}\) The soul is “the primary principle of our nourishment, sensation, and local movement; and likewise of our understanding.”\(^{121}\) The Enlightenment’s dualism bifurcated later conceptions and translations of the Latin verb *cura* into distinctions between caring and curing. Cure has come to mean a reversal or a removal of a disease and is associated with the work of physicians, while care has come to mean “a compassionate response to those whose bodies or psyches [are] in need,”\(^{122}\) and it is often associated with the work of nurses. The American nursing sisters, for example, saw their care for the patient’s body as an important aspect of caring for his soul as well.\(^{123}\) Mother Cabrini, for example, described the principal goal of a hospital was not only alleviation for corporal misery but especially help for the patient’s soul.\(^{124}\) Still today, Catholic healthcare ministry maintains the integrity of both *cura corporis* and *cura animae*.\(^{125}\)

The *Prenotanda* to the reformed rites for the *Pastoral Care of the Sick* also presumes a non-competitive relationship between the finite and the infinite. This text offers two important points. First, it insists on a dignified role of the sick particularly within the community of faith. Those suffering from illness and disease “remind others

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\(^{119}\) The following chapter explores Christian anthropology in greater detail.


\(^{121}\) *Summa theologiae*, I, Q. 76, a. 1. See all eight articles of question 76.

\(^{122}\) Bishop, 257.


\(^{124}\) Ibid., 147.

\(^{125}\) See the *Ethical and Religious Directives*, Introduction to Part 5.
not to lose sight of the essential or higher things.” The *Prenotanda* urges the sick to unite their sufferings with Christ who still suffers with them. In so doing, the sick, “show that our mortal life is restored through the mystery of Christ’s death and resurrection.” In other words, the sick are not just passive individual patients helplessly dependent on the care of others. This vision of the vulnerably ill declares them capable of actively contributing to the welfare of the people of God. Second, the *Prenotanda* witnesses to the unity between the body and soul when it exhorts all healthcare practitioners to tend to both aspects of the patient. It states, “doctors and all who are dedicated to helping the sick should consider it their duty to do whatever they judge will help the sick both physically and spiritually.” The rite’s introduction suggests that a patient’s physical condition can affect him spiritually, and his spiritual life can affect him physically. Thus, it behooves clinical practitioners to tend to both aspects of the men and women for whom they care.

A second fundamental concept that fueled the early Christian ministry of care is prayer, especially the liturgy. Liturgical prayer structured the early monastic life. The liturgy’s psalms, canticles, epistles, and the gospels tell of God’s healing and saving activity for all men and women. Monks formed by the richness of the biblical world fittingly became the founders of Western hospitals and provided respite and loving care to the destitute sick. As religious communities grew beyond monasticism to include

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127 Ibid.
128 Ibid., §5, p. 583
129 Ibid., §4, 582–583.
130 Resources such as the *Ethical and Religious Directives for Catholic Health Care Services* help to understand what this might mean and what it could look like. See Part Three: The Professional-Patient Relationship.
mendicant and apostolic orders, prayer remained a centralizing feature. Their commitment to a life of prayer informed the work they undertook to build up the reign of God on earth. The Second Vatican Council reiterated the importance of the liturgy as a grounding force for a religious community. It stated that a community’s prayer “should be nourished by the teaching of the Gospel and by the sacred liturgy, especially by the Eucharist.”

Kauffman views a seamless interaction between the prayer life of the religious and their ministry to the sick. He writes, “they brought their ministry to prayer in chapel and their prayer life was frequently embodied in ministry.” Furthermore, the Eucharist held great import for the American sisters and their ministry of health care. The daily rhythm of liturgical prayer makes the religious mindful of the rising of the sun and its setting, the creation of the world and its final fulfillment at the end of time, the birth and life of Jesus as well as his passion, death and resurrection. This ongoing reminder and celebration of God’s omnipresence and fidelity provides the religious with a particular understanding of life and death. In turn, it influences and animates the care offered to those enduring the vulnerabilities of illness and the burdens of dying. Because they had been formed with the Catholic imagination to be attuned to the presence of Christ in the eucharistic liturgy, it was a natural step for superiors to urge their sister and brother caregivers to see the mystical body of Christ in the patients for whom they cared.

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132 Kauffman, _Ministry and Meaning_, 1.
133 Ibid., 87; see also 57.
As a laywoman, Saunders had been influenced by the Sisters of Charity when she worked at their St. Joseph’s hospice throughout medical school. Saunders herself fostered a life of daily prayer and integrated ritual prayer in the flow of operations at St. Christopher’s. Prayer occurred every morning and evening in the wards, and all staff led prayer. It was not the exclusive role of the chaplain. Nurses, auxiliaries, and volunteers were expected to pray, and together they gathered at a patient’s bedside and prayed from a card.\textsuperscript{135} Prayer occurred collectively and individually, and staff offered prayers for patients as well as families.

Saunders kept her emphasis on prayer in the shadows, at least initially, as she traveled to the U.S., Canada, throughout Europe, and other destinations promoting the different models of end-of-life care. Her initial reticence regarding the centrality of the Christian life and prayer at St. Christopher's came at a time when medicine increasingly strengthened its reliance upon efficiency, effectiveness, empirical studies and statistics. Modernity so prizes the scientific method that prayer itself has been subjected to medicine’s epistemologies and validating criterion.\textsuperscript{136} Medicine's myopic focus on scientific truths overtook palliative care, adjudicated which aspects of it were beneficial and which were not, and thereby stripped it of its original Christian identity. Bishop's assertion seems quite plausible that palliative care participates in a denial of death primarily because it flows from medicine's operative epistemologies of efficiency and effectiveness. We must be careful, however, to avoid blaming medicine alone for the

\textsuperscript{135} Du Boulay, Cicely Saunders, 126–129.

\textsuperscript{136} Leanne Roberts, Irshad Ahmed, Steve Hall, and Andrew Davison, “Intercessory prayer for the alleviation of ill health,” \textit{Cochrane Database System Review}, 1 (2009). This evidences the broad reach of reductionism. Such studies negate central functions of prayer: to unite us with the Divine, to draw the earthly and finite into the infinite, and to participate in the ongoing exchange of life and love within the Triune God. Such studies, however, only examine how prayer might affect individuals here and now.
secularization of Saunders' vision.\textsuperscript{137} It would seem that Saunders' religiously and medically inspired vision of care for the destitute sick and dying would have found a natural home within Catholic healthcare, particularly in the U.S. Here in this country, Catholic communities of women religious had long been caring for the dying,\textsuperscript{138} and they sponsored hospitals and other health facilities, amassing large healthcare systems that care for a significant proportion of the American population.

Catholic healthcare, however, did not sustain the level of institutional change within medicine that Saunders began. Individual Catholic healthcare systems have embraced palliative care only relatively recently when compared to Saunders’ newfound fame in the 1970s and early 80s.\textsuperscript{139} There are many reasons for this missed opportunity,

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  \item \textsuperscript{138} Cathy Siebold singles out two notable examples of early American hospices in her work, \textit{The Hospice Movement: Easing Death’s Pains} (New York: Twayne Publishers, 1992), 22–27. The first and arguably the most famous is Saint Rose’s Hospice in lower Manhattan. Its foundress, Rose Hawthorne Lathrop, daughter to the American writer Nathaniel Hawthorne, took religious vows after the death of her husband. She became Mother Alphonsa and founded a Dominican community of women in 1900, known as the Hawthorne Sisters. Their charism is to serve the needs of the dying. They maintain three homes for the dying in the U.S.: Rosary Hill Home in Hawthorne, NY; Sacred Heart Home in Philadelphia, PA; and Our Lady of Perpetual Help Home in Atlanta, GA. Harold Braswell, a doctoral student at Emory University has a forthcoming dissertation that examines the life, religious practices, and the care provided by the Hawthorne Sisters in Atlanta. See also, Theodore Maynard, \textit{A Fire Was Lighted: The Life of Rose Hawthorne Lathrop} (Milwaukee: Bruce Publishing Company, 1948); Katherine Kurz Burton, \textit{Sorrow Built a Bridge: The Life of Mother Alphonsa, Daughter of Nathaniel Hawthorne} (Garden City, NY: Image Books, 1956, c. 1937).
  \item \textsuperscript{139} Seibold’s second example is Calvary Hospital that opened in New York City in 1899. It was founded by Catherine McPardan and a group of Irish Catholic laywomen who provided in-home support to the dying. As it grew its staff included several different groups of Catholic women religious.
  \item Various Catholic healthcare organizations began individual and more systematic palliative care programs in the last two decades. Recent years have witnessed greater and renewed interested in further developing these programs. The coalition of Catholic health ministries that comprise the Supportive Care Coalition formed in 1994, nearly a decade after Dame Saunders began giving lectures in the U.S. The Catholic Health Association suggests that the current culture of medical and administrative leadership today within Catholic healthcare may inadequately support a more authentic and maturely developed palliative care program. See, Ron Hamel, “Palliative Care Needs a Culture to Sustain It,” \textit{Health Progress}, (Jan.-Feb. 2011): 70–72.
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some of which pertain to historical contexts and the differences in the healthcare systems of the United Kingdom and the U.S.\textsuperscript{140}

When Saunders first began lecturing about pain management and end-of-life care, most invitations came from academic medical institutions, which have been primarily outside of the scope of Catholic healthcare systems. Catholic healthcare in the U.S. has traditionally focused on care for the indigent, poor, and rural populations. During this time, Catholic healthcare in the U.S. contended with other mammoth changes. External factors such as the passage of Medicare and Medicaid in 1965, effected dramatic changes and required increasing administrative and financial expertise. Social forces, including the civil rights movement, the increasing pluralism, and the secularization of twentieth-century America impacted Catholic healthcare.\textsuperscript{141} However, the impact of an historical event internal to Catholicism weakened the ability of leaders in Catholic healthcare to receive, implement, and promote Saunders' vision of palliative care—the Second Vatican Council.

**The Second Vatican Council – Renewal and Unexpected Decline**

While Cicely Saunders dreamed of a transformation in medicine, a different transformation swept through the Catholic Church with the Second Vatican Council (1962-1965) that had an effect on the religious communities that sponsored Catholic healthcare ministries in the U.S. Following the Council, communities of women religious experienced a precipitous decline, both in new vocations and the overall

\textsuperscript{140} Siebold, *The Hospice Movement* 70–73.
population of their communities. These declines coincided with a steady transfer of executive positions in their healthcare ministries into the hands of lay leadership. The women religious knew that the future survival of their hospitals depended on expertise that the laity would best provide.\footnote{The U.S. Congress passed the Medicare and Medicaid programs in the same year that the Second Vatican Council ended. Barbra Wall notes that in this time the professional roles of the women religious in the hospitals changed. Over time, they moved out of nursing and those who remained in the healthcare setting, assumed roles in pastoral care. Regarding the impact of the Second Vatican Council on Catholic healthcare ministry, see Wall, 7–9.}

Christopher Kauffman suggests that as medical modernization progressed and as the number of American sisters dwindled at the bedsides and the boardrooms of their Catholic hospitals and healthcare systems, they struggled to preserve their transcendent, spiritual grounding. Something essential was lost. Lost was a vision of ministry to the destitute sick and the poor that is deeply informed by the paschal mystery. I am not suggesting that lay leaders abandoned the Catholic commitment to care for the poor, the vulnerable, and the dying. Rather, they have lost a rich understanding of \textit{why} this commitment is important and from \textit{where} this commitment flows. It flows from the Gospel narratives. Having an intellectual grasp of the importance for caring for the poor, the vulnerable, and the dying does not suffice. For the women religious, their commitment to care flowed from the totality of their lives. This transformation shares similarities with the loss of the vision for “total care” that resulted as hospice and palliative care grew beyond St. Christopher’s. The foundation of faith that inspired Saunders gave way to the championing of clinical practices and the deployment of assessment tools.\footnote{Bishop, \textit{The Anticipatory Corpse}, 275–6.
Losing a sense of the paschal mystery to ground a healthcare ministry has resulted in Catholic healthcare ministries today pursuing palliative care programs with no discernable distinction from other-than-Catholic providers. Saunders’ revolution in medicine came about because she approached her work with the dying with a distinctive vision. For years she had grounded her prayer life in Word and sacrament. A life that is steeped in a living practice of faith, especially the paschal mystery—not merely in a gnostic-like intellectual understanding, but rather a life that is continually informed and renewed by the promise of new life—views palliative care not only as medical discipline but as a lived continuation of the life of Christ Jesus and the opportunity to await for God to once again fulfill God’s covenant to bring about new life. The women religious leading their growing healthcare ministries had been formed by years of prayer, the routine of daily liturgy, and the cyclical nature of the church’s life. Their successors, conversely, were formed and educated in MBA programs and secular nursing and medical schools. The rhythms of the liturgical cycle and daily liturgical prayer that grounded the life of the vowed religious, effected in them a deep faith in God who has promised to abide with God’s people even when an individual becomes “overmastered by disease.”

In other words, if we accept that Dame Saunders created something new within the horizon of twentieth-century medicine that evaded the undesirable characteristics of medicalized dying, and if we value sustained efforts to stave off medicalized dying, or

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144 In Heute Hill et al, “How Four Catholic Systems Approach Palliative Care,” each contributor described their palliative care programs in terms of clinical needs, objective criteria, the eight domains of quality palliative care, reimbursement and financial feasibility, a cost-savings calculator, standardization, and measuring and monitoring. Only one of the four obliquely referred to palliative care as an integral part of their ministry’s mission when it described palliative care as an “important opportunity…to live up to our reputation.”
quite possibly transform it, then one possible remedy is to retrieve and reintegrate religious practices that provide a counter-narrative to that which medicine has built up over the last century. In the Catholic tradition, that counter-narrative is told and is on full display through the liturgy. To explore what the Christian liturgical tradition could provide to the practice of palliative care in a Christian healthcare setting, I want to examine how the paschal mystery reorients the believer, whether a patient, surrogate decision-maker, nurse, physician, or administrator, toward an understanding that death is neither defeat nor the end.

The Paschal Mystery

At the heart of the Catholic Eucharistic celebration, immediately following the institution narrative over the bread and wine, the faithful sing out, “We proclaim your Death, O Lord, and profess your Resurrection until you come again.”

Like medicine, Christian liturgy attends to the human reality of death, and unlike medicine, the Christian story does not end there, but rather it professes God’s victory over death in Christ’s triumphant resurrection and ascension. The Christian liturgy commemorates and celebrates the paschal mystery, that is, the incarnation, life, resurrection from the dead, and glorious ascension of Jesus Christ. Throughout an entire liturgical year the faithful are drawn into the paschal mystery. The year’s celebrations proclaim the scriptures and celebrate the anticipation of the coming Messiah, the Incarnation of God, Jesus’ ministry in Galilee and proclamation of the reign of God, Jesus’ solidarity with human sin and

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suffering, his journey into Jerusalem, his crucifixion and death, resurrection, ascension, and outpouring of the Holy Spirit.¹⁴⁷

Bruce Morrill situates the paschal mystery in relation to God’s covenantal promise to deliver Israel into freedom. Jesus fulfills this promise by his death and resurrection that radically transforms the Hebraic understanding of covenant. The mystery revealed by the liturgy describes death differently for the gathered faithful as compared to the narrative provided by medicine, which perceives it as a meaningless end. For Morrill the paschal mystery is “the mystery revealed at the heart of the Christian faith, the revelation that the strength of death is past and that the promised covenant of love written on human hearts is underway.”¹⁴⁸ In the resurrection, God has revealed something new and utterly unexpected.¹⁴⁹ The essence of Christian faith is paschal, which means that it pertains to the Passover, to God’s covenant of love, and specifically to Jesus. Morrill writes, “the specific content of this paschal mystery needs to be repeatedly expounded through word and sacrament lest we lose sight of what God we are worshiping.”¹⁵⁰ This is why I propose the Christian liturgical life as one important way to respond to the deficiencies that Jeffrey Bishop, Sharon Kaufman and other critics have cited regarding the contemporary palliative care programs.

As I have outlined earlier, palliative care is appropriate for those patients who experience chronic and terminal illnesses. Medically, we know that such patients will

¹⁵⁰ Morrill, Divine Worship and Human Healing, 10.
never improve and that they will gradually decline toward death, perhaps over a period of many years. In medicine’s technologically saturated environment, it is tempting to look toward science and technology as a way out with the hope that death will not come. This point receives greater attention in the following chapter. The more patients look to medicine, the more likely for death to be suppressed and denied. Yet, the Christian liturgical practice of faith keeps death before us, but it is coupled with a confident hope that the same Spirit of God who raised Jesus from the dead will also give us a share in that same glory.

We must also caution that the liturgy is not escapism. The Christian liturgy “is not a matter of taking believers out of the world for a moment but rather of immersing them more deeply in the mystery of God’s paradoxical purpose for it over time.”¹⁵¹ It draws us into the life and memory of God’s actions and promise of human redemption to transform us by the power of the Holy Spirit and gives us a foretaste of eternity when God will be all in all (1 Cor. 15:28).¹⁵² The scholarship of liturgical theologians can help us appreciate the transformative nature of liturgy and therefore provide further connections to palliative care.

**Liturgal Theology**

The early Christian communities followed Jesus’ command to gather, to open the scriptures, and to break bread together—to “do this in memory of me” (Lk 22:19).¹⁵³ Having been nourished by their memory of his preaching the reign of God, his passion,

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¹⁵¹ Ibid., 10.
¹⁵² Ibid., 11.
his death, and his resurrection, they set out to all nations to baptize and teach (Matt 28:19–20). These worshipping practices by the Christian community had been occurring long before the community came to articulate and codify its beliefs in creedal and doctrinal statements. To this point, scholars of liturgical theology note how worship gave rise to theological reflection, and thus the phrase ascribed to Prosper of Aquitaine, *lex orandi, lex credendi*—the law of worship founds or establishes the law of belief.\(^{154}\) Aidan Kavanaugh comments how something far more significant than just knocking at God’s door occurs in worship. He writes, “the living God is present to the church. [It] is not a theological theory; it is a real presence which is there to affect, grace and change the world. It is an active real presence of God accomplishing his purpose as he will by the gift of himself in his Son through the Holy Spirit.”\(^{155}\) As explained previously in the chapter when describing the symbiotic relationship the women religious experienced between their prayer and their ministry of care, liturgy is neither something separate from the church, nor is it just one ecclesiastical action. It is the church being itself. Kavanaugh declares, “It is simply the church living its ‘bread and butter’ life of faith under grace, a life in which God in Christ is encountered regularly and dependably as in no other way for the life of the world.”\(^{156}\)

David Fagerberg notes how “liturgy is not just ritual; it is a way of living and a way of thinking, expressed ritually.”\(^{157}\) It is the faith of the church in motion.\(^{158}\)

Fagerberg’s writing on liturgical theology provides an explanation to understand the

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\(^{155}\) Ibid., 8.

\(^{156}\) Ibid., 8; See also 74–76.


\(^{158}\) Ibid., ix. See also, Kavanagh, 8.
connection between liturgy and caring for the destitute sick and dying. Earlier I proposed that two foundational Christian concepts have sustained the Gospel mandate to care for the vulnerable sick and poor, namely, liturgical prayer and a Christian anthropology uniting *cura corporis* and *cura animae*. Fagerbeg asserts that liturgy is necessary precisely because men and women comprise of body and soul—a unity that uniquely marks them different from the rest of creation. In the event of the incarnation, God took neither an animal nature nor an angelic nature, but rather a human nature. The incarnation was the flowering of the divine life originally implanted within all men and women who have been created in the image and likeness of God (Gen 1:26). Because we were created to share in the divine life, standing in the real presence of Divine Mystery offering our praise and gratitude to God is basic to us. It enables healing from the divisions that original sin has wrought. Fagerberg argues that liturgical theology is necessary to recreate the beauty and peace lost by original sin. He writes, “since that cataclysm, material things have held so much potential to make us amnesiac that the ascetical tradition warns us to discipline the body, warns about material things, and even warns about the danger of these things recurring in memory and imagination. We have lost our equilibrium.” Liturgy restores it. The liturgy once preserved the equilibrium with regards to an appropriate level of medical care for the destitute sick, the chronically ill, and the dying without succumbing to medicalized dying. The latter becomes problematic in the absence of a practice of faith. When available, we cling to technology. As the following chapter will explain, the availability of technology is virtually ubiquitous. We grasp what is materially available out of fear of the immaterial life.

159 Ibid., 22.
160 Fagerberg, 26.
hereafter—a temptation all the more enticing when something like liturgy is unavailable to orient men and women toward a life beyond this immediate familiar one that we know.

Fagerberg’s contribution to liturgical theology is the inclusion of asceticism.\textsuperscript{161} He describes it as a product of Christian liturgy, and it is “necessary to think straight—about ourselves (anthropology), the world (cosmology), and God (theology).”\textsuperscript{162} The liturgy grounded the early Christian monks, and it grounded Dame Saunders, tacitly teaching both of them a Christ-like asceticism. Asceticism, communicated through the liturgy, “corroborates the death of Christ in our own bodies by taming those passions that accompany life-in-the-body so that we may notarize with our hope that death has not been victorious. Instead, death, when grasped in a radical act of faith, has been made a portal to the new age.”\textsuperscript{163} The liturgy, which makes present and celebrates the paschal mystery, possesses the potential to tame the passions and our fears of death. It strengthens the Christian believer’s faith in the Reign of God and the resurrection of the dead. It is for these reasons that I seek to link palliative care and the liturgy. The asceticism embedded in the liturgical practices makes us “think straight” about our human finitude and mortality. It helps us see more clearly the limits of medical progress and technology, and it reveals to us the unfailing promise of God to abide with us in life, suffering, and death, leading to new life in the resurrection.

The liturgy as the primary action of the Church forms the moral character of the gathered faithful, or what some have described as \textit{lex orandi, lex vivendi}.\textsuperscript{164} The

\begin{footnotes}
\item[\textsuperscript{161}] Fagerberg, \textit{Liturgical Asceticism}, (Catholic University of America Press, 2013).
\item[\textsuperscript{162}] Fagerberg, \textit{Theologia Prima}, 27.
\item[\textsuperscript{163}] Ibid., 30.
\item[\textsuperscript{164}] Robert Barron, “
\end{footnotes}
structure and the flow of the liturgy—the gathering, the signing oneself with the Trinitarian formula, the proclaiming and preaching of the Word, the offering, the eating and drinking of divine communion, and the sending—all form a pattern and “practice that most completely embodies the kind of person that a disciple ought to be.” At the conclusion of the liturgy, the celebrant tells the faithful, “Go in peace, glorifying the Lord by your life.” The encounter with the living God through the liturgy makes the paschal mystery present to the faithful and prepares them to offer their lives as witnesses to the mysteries celebrated.

**Sacrosanctum Concilium**

The Second Vatican Council’s Constitution on the Sacred Liturgy, *Sacrosanctum Concilium*, placed the paschal mystery at the heart of the liturgical reforms. This initial document of the Council signaled that the renewal of the Church entails a renewal of the Eucharist because liturgy provides a privileged encounter with Christ *par excellence*. *Sacrosanctum concilium* states that “every liturgical celebration, because it is an action of Christ the priest and of His Body which is the Church, is a sacred action surpassing all others; no other action of the Church can equal its efficacy by the same title and to the same degree.” This means that all other ministries of the church, as important as they may be, such as the sacredness of tending to the dying, visiting the ill and imprisoned, or feeding the hungry and standing up to injustices—no matter how virtuous, holy, and unquestionably important those actions are, none surpass the importance of the liturgy.

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165 Barron, 37.
166 *Roman Missal*, The Order of Mass, §144, p. 657.
167 *Sacrosanctum concilium*, §2, 5.
168 Ibid., §7.
The liturgy orientates the lives of the faithful differently as compared to medicine. Among the very first words that the Council spoke to the world, it asserted that through the liturgy men and women become aware of themselves in the world and yet, not fully at home in it as they are “directed and subordinated to the divine.”\textsuperscript{169} The liturgy situates men and women as pilgrims on a journey toward the divine. \textit{Sacrosanctum concilium} stresses that the whole liturgical life is founded upon the paschal mystery of Christ, who has won for us salvation and freed us from death. In other words, death has already been defeated, not by medical therapies, aggressive interventions, scientific breakthroughs, and curative pharmaceutical cocktails. The Eucharistic celebration provides the faithful with a foretaste of the eternal banquet and the sustenance to continue on that journey.\textsuperscript{170} It celebrates the victory and triumph of Christ’s death and the gathered community gives “thanks to God for his unspeakable gift (2 Cor 9:15) in Christ Jesus...through the power of the Holy Spirit.”\textsuperscript{171} Cicely Saunders especially appreciated the metaphor of the human pilgrimage, which was why she accepted the suggestion of one of her patients to name the hospice after St. Christopher, the popular patron and protector of travellers.\textsuperscript{172}

More concretely, the Council endeavored to counteract the malaise many faithful experienced in the pre-conciliar liturgy by emphasizing participation and by connecting the liturgy to all other aspects of life—cosmic, communal, and individual.\textsuperscript{173}

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\item \textsuperscript{169} Ibid., §2.
\item \textsuperscript{170} Ibid., §8.
\item \textsuperscript{171} Ibid., §6.
\item \textsuperscript{172} Du Boulay, §55.
\item \textsuperscript{173} The Council’s Constitution on the Sacred Liturgy affirmed Pius XII’s 1947 encyclical, \textit{Mediator Dei} that joined the chorus of liturgical scholarship calling for greater participation of the laity in the liturgy. Participation, however, should not be reduced to or equated with “doing” a specialized ministry such as serving as a minister of hospitality, lector, cantor, or acolyte. Today in nearly all parishes in the U.S., lay men and women capably embrace the responsibility of fulfilling these roles. Doing so certainly helps their sense of connection to the ritual action. But the notion of participation intended by the Council and liturgical reformers does not depend upon the individual performing a specified liturgical role. The
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Sacrosanctum concilium emphasizes that the effects of the liturgy depend on something more than mere observation or attendance by the faithful.\textsuperscript{174} It exhorted the faithful to participate fully, actively, and consciously in the divine mysteries.\textsuperscript{175} In other words, their whole lives, body, mind and soul are to be brought before the real, living presence of Christ. Like the story of the man born blind who brought his entire life before Jesus (John 9:1–41), believers who come to experience the real presence of Christ Jesus can experience lives transformed by grace. In the minds of the reformers and affirmed by the Council, active participation in the liturgy aims to engender the transformation of society.\textsuperscript{176} Sacrosanctum concilium after all, describes the liturgy as the source and summit of all activity and ministry of the Church.\textsuperscript{177}

The early Christian monks were successful with their ministry of care because of their commitment to encounter the real presence of Christ in liturgy. They began to see their actions toward the destitute ill and dying ought to be markedly different than that of the Greco-Romans who left the infirm to die in roadside ditches. Through their liturgical whole assembly is called to participate in the liturgy. This refers to an inner disposition of receptivity to God’s action through the rites. It entails developing a liturgical spirituality. Mary Collins notes that participation is not self-evident and not univocal. It is culture specific and thus, it necessitates reflection. She also notes that various circumstances hinder participation. In the U.S. two obstacles to fuller participation include a culture of heightened individualism and a preoccupation with the ordained priest as a mediator of grace and redemption. See, Mary Collins, “Participation: Liturgical Renewal and the Culture Question,” in The Future of the Catholic Church in America: Major Papers of the Virgil Michel Symposium,” ed. John Roach (Collegeville, MN: Liturgical Press, 1991), 20–42.

\textsuperscript{174} Sacrosanctum concilium, §11.
\textsuperscript{175} Ibid., §14. See also 48, which states in part, “The Church, therefore, earnestly desires that Christ’s faithful, when present at this mystery of faith, should not be there as strangers or silent spectators; on the contrary, through a good understanding of the rites and prayers they should take part in the sacred action conscious of what they are doing, with devotion and full collaboration.”

\textsuperscript{177} Sacrosanctum concilium, §10.
practices Christian monastic communities had immersed themselves in Christ’s proclamation of the fullness of life and love for the sinner, the sick, and the vulnerable. Quite similarly, Cicely Saunders knew this history and engaged in these practices as well, thereby allowing her life to be formed by the pattern of the paschal mystery.

Summary

If we follow Bacon’s initial inspiration that men and women hold the capacity to do something to prevent being overmastered by disease, and if we accept modernity’s bifurcation of body and soul, then we tether ourselves to medicalized dying. What I am beginning to explore is the possibility that the Christian liturgical tradition, with celebration of the Eucharist at its core, opens up the hearts and minds of men and women to understand human sickness and death in a way informed by the incarnation and resurrection of Christ Jesus. When the faithful strive to fully, consciously, and actively engage in the liturgy, it holds the power to imbue them with virtues that can be especially helpful in navigating the part of life’s journey riddled with vulnerability and chronic illness that leads to death.

_Sacrosanctum concilium_ describes the Eucharist as “a memorial of [Christ’s] death and resurrection: a sacrament of love, a sign of unity, a bond of charity, a paschal banquet in which Christ is eaten, the mind is filled with grace, and a pledge of future

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178 Ferngren argues that in the Hellenistic period, the notion of love of humanity and a concern for the well-being of one’s fellows connoted a condescending benevolence. The original meaning related to a relationship between a social superior to an inferior. There was no religious or ethical impulse for almsgiving. There was no motive for charity. Pity was given neither to the suffering nor the indigent, but rather, it was mostly reserved for the members of the upper class who experienced a reversal of fortune (Ferngren, _Medicine and Health Care_, 86–97.)
glory is given to us.” Sacrosanctum concilium, §47. This statement from the liturgy’s constitution points to the three theological virtues. The Eucharist is and celebrates “the mystery of faith.” It memorializes and keeps alive a hope in the covenant that God will never abandon God’s people, not even in death. The resurrection proves God’s ultimate and lasting victory. Moreover, the Eucharist nourishes the faithful in the hope of the future glory to be experienced in the paschal banquet. It is a foretaste of our own participation in the resurrection. As will be examined in the final chapter, the liturgy forges a bond of unity. It fosters love between God and God’s people, while it also nourishes the love among people on earth. Such faith, hope, and love filled the hospitals staffed by women religious across the growing American landscape and created an environment that once contributed to something like a tame death.

The following three chapters do not attempt to retrieve a tame death. Rather, they seek to provide sustenance and an alloy to palliative care—a palliative care more fully conceived with its original religious overtones. The religious components are specifically the liturgical practices that preserve the practice of medicine from becoming totalizing and succumbing to practices of medicalized dying. Where medicine has worked hard to excise religion from its practices, religious faith actually provides a benefit. That is the argument examined and made in the following chapter.

179 Sacrosanctum concilium, §47.
180 The Roman Missal, The Order of Mass, §91, p. 624. The celebrant, having pronounced the words of institution over the bread and wine, and showing the consecrated host and chalice to the people, chants this phrase, “The mystery of faith.” The rubrics direct the people to acclaim, “We proclaim your Death, O Lord, and profess your Resurrection until you come again.” The liturgy links faith with the dying and rising of Jesus.
Chapter 2 – Faith and Technology

Faith is the substance of things hoped for, the evidence of things not seen. (Heb 11:1)

Palliative care grew out of the awareness that while medicine and scientific advancements aim to offer intervening clinical therapies, patients need more. Medical interventions alone will fail to comprehensively provide for the patient’s needs and care. Saunders’ own Christian faith enabled her to explore that “something more” that she provided for the residents of St. Christopher’s.

Catholic and other faith-based healthcare organizations have asserted their religious traditions as the reasons for the work and ministry they enact. It deeply influences their self-identity and provides the very basis for their mission and values. Those who work in these environments will often explain that their care for the sick perpetuates the commitment to the faith, spirituality, and vision of their founders. This chapter asserts that faith provides something more profound, in fact, something more essential to medicine. This connection between faith and medicine is made clearer through the example of palliative care because those who practice it and those who receive such care face questions of ultimate concern.

Faith provides a distinctive form of knowledge, and it is one of the theological virtues. This means that faith provides more than the rationale for why a healthcare system engages in the healing ministry of Jesus Christ. In the New Testament passage from the letter to the Hebrews faith is described as the substance of hope and evidence of things unseen (Heb 11:1). As substance and evidence, faith is knowledge, and primarily it relates to the way we know God. The tradition parses the object of faith in three ways.
First, one must identify what faith knows, which is to believe that God exists. Second, faith means to believe God, to give assent to what is believed, to God, and to God’s self-revelation in Jesus Christ the eternal word made flesh. Third, one believes in God and sees God as the object of faith and the grounding of the heart’s desire. To believe in God means to direct one’s whole life, mind, and heart in the direction of God.\textsuperscript{181} Directing one’s life toward God links faith with ethics. Some scholars contend that the Hebrews passage may contain a word play that juxtaposes a sense of cowardly retreat with faith that conversely connotes a courageous move forward.\textsuperscript{182} By believing in God, the believer strives to rid himself of all that is not God. As Nicholas Lash notes, “believing in God entails not ‘believing in’…anything else.”\textsuperscript{183} We must rid ourselves of all idolatrous notions of God. We must relinquish all that we grasp onto in an effort to preserve ourselves, our lives, our livelihoods—all the many things we believe will save us and make us happy, so that our love and delight more luminously focuses on God.

Modern medicine believes in the power of technology. As explained in the opening chapter, Bacon’s admonition to his pupils and later generations of scientists to maintain a belief in God drowned in the allure of scientific discovery and technological advancements. This is why I have paired faith and technology in this chapter. Some readers may find this a strange coupling. The theological tradition more commonly links faith and reason, which itself is an importantly related topic albeit too large for this present work. The reality of medicalized dying witnesses to a strong societal belief in technology. As I will explain in the chapter, there is much in technology that is worthy

\textsuperscript{181} Nicholas Lash, \textit{Believing Three Ways in One God: A Reading of the Apostles’ Creed} (Notre Dame, IN: University of Notre Dame Press, 1992), 21.
\textsuperscript{183} Lash, \textit{Believing Three Ways in One God}, 21.
of praise, and at the same time, we must not allow it to eclipse a more primary belief in God.

More specifically, D. Stephen Long notes that many ancient Christian writers read the verse from Hebrews and all of chapter 11 through the lens of the resurrection from death. Thus, the Christian faith is decisively a faith in God’s power and love to raise the dead to new life. This means that Christians ought to engage in medical decisions that will impact their life and death in a particular way—in a way that expresses their belief in God, their hope in God’s fidelity to raise the dead just as the Spirit of God raised Jesus from the tomb, and their belief that they will enjoy God’s eternal love after they pass the threshold of death. Practicing the Christian faith in this sense presupposes the engagement of virtues. Aquinas described virtue as *habitus*, or an inner disposition that is honed by practices over time. While faith involves the intellect and will, it is also a theological virtue, which means that faith comes primarily through God’s gift enacted in the ritual practices of the church—the sacraments.

This chapter presents faith, understood as knowledge and virtue, as a counterbalancing force to technology. It focuses narrowly on critiques of the implicit promise embedded in the essence of technology that assesses its power to save men and women from illness and ultimately death. This critique will appeal to ecclesial writings from the Roman Catholic tradition and from Christian philosophical arguments. These critiques contribute to the work and aims of palliative care because most if not all of the ethical difficulties surrounding end-of-life issues relate to technology. Much of the difficulty in advancing palliative care practices involve a reconceptualization of a balanced use of technology in light of incurable chronic and terminal conditions. Thus,

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This chapter draws out the resources from the Catholic tradition that critique technology, and in so doing, it obliquely connects to palliative care. I argue that Catholic healthcare must engage these critiques with their clinical leaders in order to advance a practice of palliative care that is consistent with the original vision from Saunders and consistent with the Catholic tradition.

The chapter is structured in four parts. Since I will argue for the importance of faith as a virtue and a form of knowledge that ought to influence the acceptance and advancement of palliative care, I begin by considering significant obstacles in medicine that may resist faith. Next, I will examine the overpowering nature of technology. I specifically engage Martin Heidegger’s argument that technology is a form of revealing truth. However, its mode of revealing challenges nature and conceals other forms of truth. For Heidegger, technology’s power represents a completion of Western metaphysics. This bold argument sets up a contrast to the Catholic theological tradition. Part III examines the Catholic theological tradition in two parts and argues for a two-pronged theological critique of technology. First, I highlight the critiques contained in Catholic social teaching and other related ecclesial documents. The second prong of the theological critique entails characteristics of a Christian anthropology. This will support the argument in favor of metaphysics over reductionism, and it will make connections to palliative care in a chapter focusing primarily on technology and theology. These resources from the Christian tradition will amplify the understanding of how Dame Saunders’ faith impacted her vision for palliative care. Moreover, the analysis of Catholic social teaching and the other papal writings will reveal a development in recent decades that tie a theological vision for social transformation with the liturgical tradition.
The implication is that faith must be practiced, and thus the virtue of faith differs from manifestations of faith. Finally, the chapter will conclude by tying together technology and liturgy in an examination of the work of Christian philosopher Albert Borgmann. He engages Heidegger’s argument and proposes that focal things and focal practices, ultimately Christian liturgy, aid men and women in transcending technology’s dominance.

Part I: Medicine’s Aversion to Faith

Selling the idea to physicians, other healthcare practitioners, and administrators that faith provides a critically important role for the care of patients can be a most difficult task. Saunders herself understood this difficulty. As a result, she initially focused her international speaking engagements exclusively on the clinical factors involved in creating palliative care programs. Faith fell to the wayside. Identifying the barriers to incorporating faith is the first step in confronting or possibly removing them. I propose and examine only two barriers: reductionism and clinical experiences of patients with extreme religious views. Both concepts bias healthcare practitioners against exploring the benefits of embracing faith as an alternative form of knowledge. What is more, these examples share a common denominator—technology.

Reductionism

I begin with reductionism because it explains in different terms the problem identified in Jeffrey Bishop’s argument. He sees efficiency and effectiveness as the
driving epistemologies in medicine. These concepts came to dominate medicine as medical education grounded its methodology in anatomy and physiology. The discrete parts of the human body give rise to the complexity of the whole. When something goes wrong in the body, the physician’s training leads her to seek out the malfunctioning part and treat it. This is an example of reductionism.

Nancey Murphy, a philosopher of science and a theologian, asserts reductionism as a central metaphysical assumption of the modern era.\textsuperscript{185} She describes the view of “the hierarchy of the sciences—the picture of physics supporting chemistry, chemistry supporting the various levels of biology, and perhaps biology supporting psychology and then the social sciences.”\textsuperscript{186} In other words, the physical world comprises of “a hierarchy of levels of complexity.” The simplest things described by basic physics occupy the bottom layer and everything else, including larger and more complex organizations, builds upon this basic foundation.\textsuperscript{187}

Similarly, a hierarchy of care governs how healthcare practitioners triage multiple problems. Most basically, a patient must have oxygen and blood flowing throughout the body. When this ceases, organ failure ensues and the brain tissue dies. Clinicians can address other bodily systems and life-threatening problems after stabilizing heart and lung functioning. Reductionism reigns in the emergency department and the critical care unit. Doctors treat what must be immediately treated to stave off death. Once this is accomplished, then they move to the next level of care—those things that have the potential to deteriorate sooner rather than later and symptoms that indicate adverse


\textsuperscript{186} Murphy, “Introduction,” in \textit{Evolution and Emergence}, 1.

\textsuperscript{187} Ibid., 1.
consequences and possibly death. Lastly, medicine attends to things that over time could lead to death. Reductionism also lies at the heart of medical research, such as stem cell research and genetic engineering. If researchers can manipulate cells to never develop into tumors, then certain cancers may be eliminated. Their hypothesis rests on changing the physics of a single cell or specific gene.

Stem cell research exemplifies a key aspect of reductionism that troubles Murphy. She enumerates multiple forms of reductionism. The most pertinent for our purposes here include causal reductionism.\footnote{\textsuperscript{188} Other forms of reductionism include methodological, epistemological, logical or definitional, and ontological reductionism. Murphy further specifies one form of ontological reductionism as “atomist reductionism.” This means that “only the entities at the lowest level are really real; higher-level entities—molecules, cells, organisms—are only composites made of atoms.” Murphy has no objection to ontological or atomic reductionism. However, she concludes that the critical issues remain with causal reductionism (Murphy, “Reductionism,” 23–24).} This essentially entails a “bottom-up” chain reaction. It is “the view that the behavior of the parts of a system (ultimately, the parts studied by subatomic physics) is determinative of the behavior of all higher-level entities.”\footnote{\textsuperscript{189} Ibid., 23.}

Murphy and her colleagues counter reductionism with developments in numerous disciplines such as quantum physics, biology, cognitive sciences along with concepts from cybernetics, systems theory, information theory, complexity studies, and mathematical study of nonlinear dynamics.\footnote{\textsuperscript{190} See, John C. Polkinghorne, \textit{Quantum Physics and Theology: An Unexpected Kinship}, (London: SPCK, 2007).} All contribute to an understanding of “how complex (higher-level) entities become causal players in their own right, over and above effects of their components.”\footnote{\textsuperscript{191} Murphy, “Introduction,” in \textit{Evolution and Emergence}, 1–2.} In other words, Murphy and her emergentist colleagues
posit that complex systems exhibit new causal powers irreducible to the combined effects of lower-level causation.\footnote{Murphy, “Reductionism,” in Evolution and Emergence, 27. The term associated with the process espoused by Murphy and her colleagues is “downward causation.” Among the irreducible complex systems is theology. Murphy argues that the stuff of Christianity can be “data” for a scientific theology. See, Nancey Murphy, Theology in the Age of Scientific Reasoning (Ithaca, NY: Cornell University Press, 1990).}

Conor Cunningham sees a similar reductionism operative in the debates between religion and evolution.\footnote{Conor Cunningham, Darwin’s Pious Idea: Why the Ultra-Darwinists and Creationists Both Get it Wrong, (Grand Rapids, MI: Eerdmans, 2010).} I raise this because the suggestion that faith may provide a unique form of knowledge applicable to medicine could predictably be met with retorts that Christianity opposed evolution. The Catholic Church in particular has a long, uneven, and at times a lamentable history with science. The seventeenth-century condemnation of Galileo, the modernist controversy of the late nineteenth and early twentieth centuries, and the decades of the Church’s ambiguity regarding evolution have had long-term effects. Today, modern news media and its alternative sources, such as blogs, frequently muddle rather than clarify.\footnote{Ian Barbour bemoaned that the news media reflected greater interest in conflict, and thus, it tended to report on extreme positions from atheism or fundamentalism. Many praised Barbour for his ability to balance faith and science. See, Ian G. Barbour, Issues in Science and Religion (Englewood Cliffs, NJ: Prentice-Hall, 1966), Religion and Science: Historical and Contemporary Issues, (San Francisco: Harper San Francisco, 2000), and When Science Meets Religion (San Francisco: Harper San Francisco, 1997).} They cloud the nuance of the theological tradition. A result is that physicians who have been schooled in biology and chemistry are left with the impression that the church generally has an unfavorable perception of science, if not an antagonistic posture toward it. General impressions of serpentine historical events and theological debates pose serious problems. As David Bentley Hart argues in his rebuttal to “the New Atheists,”\footnote{This term refers to a recent boom in published works by scientists, secularists, journalists, and atheists that aggrandize the achievements of modernity and disparage any contribution of religious faith, especially Christianity. The more prominent examples include, Richard Dawkins, The God Delusion} getting history right is of preeminent
importance. That is, the New Atheists present vacuous accounts of false and incompetent histories that disable the reader from discerning Christianity’s rich legacy and influence in Western civilization.¹⁹⁶

Both Cunningham and Hart call foul on biases and stereotypes that religion is *de facto* anti-science. Nearly always, there is a backstory. Galileo’s discovery, for example, met with resistance because it challenged the church’s centuries-old reliance on Aristotelian categories of matter and form. For others like Cardinal Bellarmine (1542–1621), the greater problem concerned how to reconcile Galileo’s discovery with scriptural interpretations.¹⁹⁷ In the modernist controversy, church officials feared that scientific positivism would displace transcendence. And despite an era of ecclesial statements unleashing hostile rhetoric,¹⁹⁸ Pius XII (1938–1954) left evolution as an open

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¹⁹⁸ The First Vatican Council’s Dogmatic Constitution, *Dei Filius*, described a mutual enrichment process between faith and reason. Yet, church leaders in the decades that followed issued a series of harsh pronouncements that drove a wedge between Catholicism and the emerging sciences and more generally, the modern world. Modernism emerged largely among French Catholic intellectuals in the late nineteenth century. Its guiding dictum was that “the ancient faith must be wed to modern thought.” An especially helpful and descriptive analysis of modernism and its influence on Americanism can be found in Scott Appleby, *Church and Age Unite: The Modernist Impulse in American Catholicism* (Notre Dame, IN: University of Notre Dame Press, 1992), 1–12.

Pope Leo XIII’s 1899 encyclical, *Testem Benevolentiae*, expressed his disapproval for the excessive accommodationist stance that many American Catholics, including the hierarchy, afforded to the modern culture and its values. Rome’s critique of those wanting to pursue the new frontiers between faith and science did not stop with the Americans. The unity between faith and reason previously articulated in the Catholic tradition, unraveled with greater severity in Pope Pius X’s 1907 encyclical *Pascendi Dominici Gregis*. Pius X condemned modernism as the “synthesis of all heresies,” §39. It viewed
question. At the end of the twentieth century John Paul II (1978–2005) recognized the seriousness of the scientific research and admitted evolution as “more than a hypothesis.”

Throughout history, scientific theories and findings functioned as triggers that brought to the public fore discrepancies on unresolved theological concepts. It is not my intention to revisit these complex and lamentable episodes in Church history. My point has been to offer a possible understanding for why some healthcare practitioners may react sharply to the idea that the Christian faith can provide an important source of knowledge.

Behind all of the aforesaid controversies—reductionism, scientism, Darwinism—to some degree or another, stands technology. Science and technology are mutually dependent. The examples presented focus largely on the former. By examining technology, I hope to enlarge the discussion in ways that perhaps have been less scrutinized. Moreover, many of the difficult ethical issues that arise with chronic and terminally ill patients involve the role of technology in the patient’s care. To prepare for a more thorough engagement of what I mean by technology, I want to present two

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modernism as inherently opposed to the supernaturally endowed doctrinal tradition, and as such, it subjugated faith to reason. To be clear, not all who sought an integration of the sciences with theology were modernists, and Pascendi did not altogether quash theological investigations into the modern sciences; rather, it insisted upon an indispensable role of the Divine.

scenarios involving technology and religion in the clinical setting. The following examples will serve two purposes. First, it will further evidence why healthcare practitioners may have negative biases regarding faith as a beneficial way of knowing. And second, it will concretize the relationship between faith and technology.

**Clinical Extremes: “Do Everything!” vs. “No Treatment!”**

Healthcare practitioners may react unfavorably to the role of faith as a source of knowledge because their experiences with religious extremes have shaped their perceptions. Physicians and other practitioners confront unnuanced ideologies in the requests made by patients for or against particular treatments. Consider two examples.

On the one hand, some persons with strong religious viewpoints excessively rely on medical and technological interventions. As a result, some instances of medicalized dying occur on the grounds of religious convictions. Researchers have correlated strongly held religious beliefs with an increased use of medical interventions. On the other hand, some individuals with strong religious convictions use faith to justify an outright rejection of standard medical practices. Such individuals may espouse faith healing, meaning that if God wills the healing of illness, God will do so without the use

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of modern medicine. With their faith in hand, they await a miracle from God.\textsuperscript{201} Society and the legal system have responded to this latter extreme by intervening with medical treatments in some cases, such as those involving minor children or incompetent adults who were never competent.\textsuperscript{202}

The examples reflect opposing ends of a spectrum. One clings to a reliance on technology in the name of a religious faith. Another rejects technology in the name of religious faith. And both frustrate clinicians; they disrupt normal clinical pathways for offering medical treatments and care for patients. They challenge the normative procedures operative in medical care.

Beyond the clinical disruptions wrought by these examples, they expose a general unease among physicians in addressing issues of faith and spirituality.\textsuperscript{203} This reality conflicts with the fact that patients have indicated strong preferences for physicians to inquire about spirituality. One study discovered this to be as high as eighty-three percent of the respondents.\textsuperscript{204} A different study confirmed that the majority of patients want to

\textsuperscript{201} William E. Stempsey, “Miracles and the Limits of Medical Knowledge,” \textit{Medicine, Health Care and Philosophy} 5 (2002), 1–9. The author points out that medicine has no epistemological grounds for declaring any cure to be miraculous. Claims about miracles depend upon one’s understanding of determinism and indeterminism.


\textsuperscript{203} It needs to be noted that there is a difference between spirituality and the practice of an established faith tradition. Parsing the differences lies beyond the scope of this present work. The two, however, share commonalities. They both entail a metaphysics that transcends the physical world, and they do not limit themselves to what the empirical sciences reveal.

\textsuperscript{204} Gary McCord, Valerie J. Gilchrist, Steven D. Grossman, Bridget D. King, Kenelm F. McCormick, Allison M. Oprandi, Susan Labuda Schrop et al., “Discussing spirituality with patients: a rational and ethical approach,” \textit{The Annals of Family Medicine} 2, no. 4 (2004): 356-361. This study found a strong correlation between the patient’s desire for the physician to inquire about spirituality and recent experiences of death. When a patient had experienced a death of a close family member, or if death threatened the patient himself, the desire to discuss spirituality increased.
discuss what dying might be like along with related spiritual and religious issues with their physicians. Yet many physicians shrink from such discussion. When physicians do engage the patient in matters of dying and spirituality, patients rate the quality of the encounter poorly.\textsuperscript{205} Despite calls from the medical literature and from people of faith to explore the mutual benefit of faith and medicine, some have questioned the professional appropriateness and even the very ethics of physicians giving attention to a patient’s spiritual and religious life.\textsuperscript{206} This exemplifies modernity’s dualism of separating the spiritual from the bodily. Others, such as researchers at George Washington University’s Institute for Spirituality and Health (GWish) aim to educate and pursue issues related to spirituality and health.\textsuperscript{207} GWish offers tools for making a spiritual assessment in a clinical setting, and they have formulated techniques for incorporating spirituality as part of the patient’s history.

The disinclination of physicians to address matters related to their patients’ faith lives may fuel the fervor at the extremes—“do everything,” or “don’t touch me!” Healthcare practitioners may reluctantly acquiesce to the requests to withhold treatments. Although clinical practitioners are more adept to deploying technology, and lots of it in an effort to save a patient’s life, they can reach an unmarked line when they realize that further technological interventions will no longer be of medical benefit to the patient.

When this happens, they cagily search for some grounds to justify the cessation of


\textsuperscript{207} The GW Institute for Spirituality and Health–GWish, online \url{http://smhs.gwu.edu/gwish/about}.
aggressive treatments, a mechanical respirator or ventilator, for example. Healthcare practitioners refer to this as medical futility. It does not necessarily involve religious convictions, but often it does. Medical futility is complex and deserves closer consideration. The following discussion will draw attention to the powerful allure of technology, while also admitting medicine’s own frustration with medicalized dying.

**Medical Futility – Technology’s Dead End**

Daniel Callahan convincingly and disquietingly describes the profound social and medical transformation ignited by technology. He states, “the results are strange, often bizarre. In the name of the sanctity of life, many who would consider themselves conservative and supporters of traditional religious values are forced into a slavery of medical possibilities, held in thrall by the false god of technology.”

Callahan links the strongly held religious views of some individuals to the technological imperative. Sharon Kaufman observed this imperative in her research. She explains, “The technological imperative in medicine—to order ever more diagnostic tests, to perform procedures, and to intervene with ventilators and feeding tubes to prolong life or stave off death—is one of the most important variables in contemporary medical practice and is the source of innumerable clinical-moral qualms.”

Kaufman’s concerns reverberate through ethics scholarship that questions the morality of the quest to live forever.

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The sanctity of life perspective (Callahan’s own term) normally arises out of a Christian anthropology that upholds the intrinsic dignity of every human life made in the image and likeness of God. Life is sacred because it is an inestimable gift from God. Those espousing the sanctity of life perspective often fail to qualify their view with the Christian tradition’s teaching that the gift of human life is a penultimate good because the fullness of life, happiness, and love comes in eternity.\(^{211}\) Such unqualified emphasis on the good of human life has led to the impression that statements by bishops’ conferences or theologians favor medicalized dying.\(^{212}\) This is especially so for statements that do not carefully acknowledge not only the benefit, but also the validity of the science behind the proposed therapies. Two examples of Catholic hierarchy arguing for the moral necessity of medical technology offer further clarity.

John Paul II’s papal allocution on life-sustaining treatments and the vegetative state in 2004, ignited much debate among ethicists and confusion among clinicians.\(^{213}\) The pontiff pointed to the wide-spread clinical imprecision in describing a patient’s


\(^{212}\) See for example the Wisconsin Catholic Conference’s statement regarding Physician Orders for Life Sustaining Treatments (POLST). Many palliative care providers advocate for the usefulness of POLST as it is a means to provide continuity of care between various health care institutions and locations. Moreover, it can help to communicate and protect the patient’s wishes regarding the use or withholding of aggressive and emergency treatments including but not limited to do not resuscitate orders. A mechanism like POLST will become increasingly helpful as components of the 2010 Affordable Care Act, such as increased in-home care, become more mainstream. The Wisconsin Catholic bishops raised a number of objections. See “Upholding the Dignity of Human Life: Pastoral Statement on Physician Orders for Life Sustaining Treatments (POLST),” July 2012. Accessed online: http://www.wisconsincatholic.org/Bishops_Statement_home.cfm.

condition as a “vegetative state.”\textsuperscript{214} The claim was reasonable, yet further claims in the address drew sharp reaction from clinicians because they failed to respect established clinical standards of care. The pope said, “I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a \textit{natural means} of preserving life, not a \textit{medical act}.”\textsuperscript{215} The statement overlooks the intermediary step of \textit{surgically} placing the tube into the patient’s digestive track, as in the case of a gastronomy tube. Other less invasive means of administering nutrition and hydration, such as intravenous lines and nasogastric tubes, still involve increased risk of infection and are themselves clinically and artificially inserted.\textsuperscript{216} Clinicians immediately dismissed the remarks because of the apparent lack of careful attention to the science behind the pope’s proposal. The allocution contains important theological insights regarding patients with some of the most severe impairments.\textsuperscript{217} Yet, the apparent disregard for the clinical realities clouded the deeper theological points.

In a second example, an American Cardinal giving a public lecture in 2011, described palliative care as a veil for euthanasia and physician assisted death.\textsuperscript{218} Just about anything can be used for malicious purposes, but his statement disregards scientific findings like the lung cancer study and growing standards of care for terminal as well as

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\item[\textsuperscript{215}] John Paul II, “Life-sustaining Treatments and Vegetative State,” §4. Italics original.
\item[\textsuperscript{216}] Hamel and Panicola argued that the theological case for artificially supplying nutrition and hydration has not at all been argued.
\item[\textsuperscript{218}] Joe Bollig, “Cardinal tells Catholics not to fear death and suffering,” \textit{The Leaven}, Aug. 12, 2011; Vol. 33:4, p. 3.
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chronic conditions. Moreover, such comments undermine the efforts of palliative care professionals whose work effects an ongoing reflection on the essence of technology. Such statements from members of the Catholic hierarchy tend in the direction of the technological imperative, particularly in instances in which the patient would die if not for the technological therapeutic intervention. A pro-life stance that unscrutinizingly places faith and trust in the power of medical technologies risks overstating the tradition, and perhaps, paradoxically subverting faith.

Both scenarios, the comments from John Paul II and the American Cardinal, demonstrate a curious ability of technology to impose itself onto the minds of men and women to create a set of expectations and efficacious results. These comments come dangerously close to idolizing technology. In other words, it can appear that they too closely follow Francis Bacon’s vision that scientific and technological developments will wholly stop the advancement of human pathological conditions. As Lisa Sowle Cahill has taught, “Ironically, the insistence of some on sustaining life by artificial nutrition, as long as possible, and in the most desperate of circumstances, reinscribes technological domination over the experiences of decline and death, rather than referring those

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experiences back to the more intimate circles of love, friendship, family and church."  

Such positions also fail to adequately express the Catholic tradition’s understanding that human life is a penultimate good. However, with the birth of medicalized dying in the twentieth century, technology not only dominates in the medical environment, but it has also worked its way into the very structures of human thinking. Emerging research shows that it may even be stealing away our memory.  

A tendency in an overly zealous support for the sanctity of life can lead to medicalized dying. Callahan describes how scientific progress and the sanctity of life mutually entrap and stymie one another. He writes:

For its part, by treating all the causes of death as avoidable evils...medical science has held out the hope that the causes might be eliminated—and has made the promotion of that hope a moral imperative. For its part, a capacious notion of the sanctity of life is ready to play along with scientific ambition: if life is sacred, and death is evil, then it becomes our common duty to support whatever will reduce or eliminate death and enhance life.

The problem lies in the assumptions embedded in an unqualified understanding of the sanctity of life. It implicitly accepts medical interventions as good. It neither engages adequately the epistemology operative in medicine nor the technological paradigm to which it is tethered. As Jeffry Bishop argued, medicine’s inextricable association with technology has created the perception that together they can fix just about anything in the human body. That is, until it cannot.

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Medicine succumbs to human mortality, perhaps no more dramatically than when a doctor invokes the institution’s futility policy. Such policies, whether made by legislatures or by healthcare institutions, did not exist fifty years ago. They were unnecessary. But the advancing pace of biomedical technology, and an operative epistemology that posits death as the enemy, have both created the expectation that medicine can fix whatever fails within the body. When a physician reaches the point of describing further medical treatments as futile, this reflects the power of a systemic pathology beyond the practice of any particular doctor. The systemic problems are further evidenced by the research indicating that doctors die differently from others in society. Although they deploy technology everyday onto the dying bodies of their patients, they want much less of it for themselves personally. These criticisms are not an indictment of an individual physician’s poor practice. Many times physicians have worked very hard to try and communicate to a patient and surrogate decision makers that

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further medical interventions are not likely to change the clinical realities. Often, it is the patient or the patient’s family that requests further aggressive interventions.

Besides the patients who want all available medical treatments, at the other end of the spectrum are those who fear being held prisoner by medical technologies and thus espouse a death by choice.\textsuperscript{226} The unfortunate irony in this latter example is the use of technology to escape its own tyranny. And the data suggest that the socially privileged—arguably those who have most enjoyed, profited, and used the benefits of technology—are the ones advocating for assisted dying.\textsuperscript{227}

Cahill, Callahan, Ariès, and to a lesser degree, Bishop, have all identified technology as a primary culprit in feeding the powerfulness and pervasiveness of medicalized dying. Cahill comments that “modern science and technology supply the major moral and hermeneutical framework within which death is considered in modern culture.”\textsuperscript{228} To elucidate this complex and comprehensive characteristic of technology and our human reliance on it, I turn to Martin Heidegger. His reflections in \textit{Questions Concerning Technology}, will help to appreciate why people cling to medical technologies in times of vulnerability and illness. From the Heideggerian perspective, they can hardly help but do so.

\textbf{Part II: Martin Heidegger—Technology \textit{Challenging} Nature}

\textsuperscript{226} \textit{Must We Suffer our Way to Death? Cultural and Theological Perspectives on Death by Choice}, ed. Ronald P. Hamel and Edwin R. DuBose (Dallas, TX: Southern Methodist University Press, 1996).


\textsuperscript{228} Cahill, \textit{Theological Bioethics}, 70.
Heidegger: Technology As Reason

In writings late in his career, Martin Heidegger reflected on technology’s omnipresence in the modern world. Heidegger brought his own voice to a conversation that preoccupied other twentieth-century thinkers. Technology is not just a human enterprise. It does not consist of gadgets, instruments, or machines that aid in producing or consuming things. Technology is much more comprehensive.

Heidegger’s central claim is that Being discloses itself via technology. It surrounds us, and we live in it. Technology is so pervasively omnipresent and uncontrollable, that Heidegger contended it had become our destiny. No politics, no “planning” or “the market” can manipulate or change it. Nothing remains untouched by technology—human senses, attitudes, reactions, and experiences of time and space. Technology mars nature and the sacred, destroying the very ground that sustains it. The plotline of 1984 blockbuster film *The Terminator*, represents an exaggerated example of Heidegger’s insight. In the movie, a cyborg assassin played by Arnold Schwarzenegger, belongs to an artificial network of computers and machines. The evolution of the machines reaches such sophistication that they attempt to overtake the world and destroy the very intelligence that brought them into being, namely the human race. The movie exemplifies how technology encompasses more than just the sum of its parts and machinery. It has its own logic.

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231 Safranski, 396.
For Heidegger, technology is no mere means; it exceeds an instrumental utility.

Moving beyond the gadgets associated with technology, the German philosopher focuses on the essence of technology. For him, “technology is a mode of revealing.

Technology comes to presence in the realm where revealing and unconcealment take place, where alētheia, truth, happens.” Revealing refers to a full sense of “bringing-forth,” to pass from concealment into unconcealment. He writes, “The revealing that holds sway throughout modern technology does not unfold into a bringing-forth in the sense of poiēsis. The revealing that rules in modern technology is a challenging [Herausfordern], which puts to nature the unreasonable demand that it supply energy which can be extracted and sorted as such.” The German thinker sets up a dichotomy between challenging nature and letting something emerge according to its nature. Two examples will serve to clarify.

First, Heidegger reflects on the nature and beauty of the Rhine River where he contrasts the differences between a mill and a power plant situated on its banks. The mill relies upon the natural force of the wind. The usefulness of the mill depends upon whatever nature gives. It respects the natural order of the universe. This stands in contrast to the modern, technologically advanced power plant that fundamentally

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233 Martin Heidegger, “The Question Concerning Technology,” in Basic Writings: From Being and Time (1927) to The Task of Thinking (1964), ed. David Farrell Krell (New York: Harper and Row, 1977), 295. Heidegger contrasts the contemporary phenomenon of technology with that of the ancient Greek understanding of technē. The latter “is the name not only for the activities of the craftsman, but also for the arts of the mind and of the fine arts. Technē belongs to bringing-forth, to poiēsis; it is something poetic” (Ibid., 294). What is more, Heidegger notes how Plato linked technē with epistēmē, both are terms for a broad consideration of knowing.

234 Ibid., 293. In the Greek sense, bringing-forth includes both physis and poiēsis. It includes things brought forth by a craftsperson or artist, as well as a bursting forth in nature, like that of a blossom or an emerging thunder cloud.

235 Ibid., 296.
transforms the river. The power plant does not simply receive, but rather expects and seemingly commands the river to supply pressure that turns turbines. That then thrusts electrical currents into lines crisscrossing the countryside. An interlocking ordered process creates a situation whereby “even the Rhine itself appears as something at our command.” Heidegger explains how “the river is dammed up into the power plant. What the river is now, namely, a water-power supplier derives from out of the essence of the power station.” It is in this sense that Heidegger views the essence of technology as challenging or “setting-upon.” The power plant no longer stands in respect of what the river may naturally provide. It challenges and makes demands of the river.

This challenging by technology differs from natural emergence. Consider this second example. It was said that when Michelangelo approached a block of marble, he could envision the beautiful figure entrapped within it. His art entailed allowing the figure to emerge. He could not command the figure out of the stone. A flaw, a crack, or a vein in the marble could prevent the great artist from making certain cuts, and so, respecting the stone’s nature, he modified his own plans to allow the figure to emerge on its own terms.

Contrary to emergence, the unconcealment of modern technology “is a challenging which puts to nature the unreasonable demand that it supply energy that can be extracted and stored.” The essence of technology unconceals to designate and order everything as continually available, unlimitedly manipulable, and immediately on hand as

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236 Ibid., 297.
237 Ibid., 296. This reflects a reductionism operative within the essence of technology. Similar to Nancey Murphy’s discussion on the hierarchy of the sciences and reductionism, Heidegger connects technology’s core essence to physics. See, Heidegger, “The Question Concerning Technology,” 295, 302–304.
“standing-reserve,” with an expectation that technology possesses a saving power.

Technology’s totalizing command over nature is unavoidable. Heidegger writes, “The essence of modern technology starts man upon the way of that revealing through which the real everywhere...becomes standing-reserve. ‘To start upon a way’ means ‘to send’ in our ordinary language. We shall call the sending that gathers [versammelnde Schicken], that first starts man upon a way of revealing, destining [Geschick]. It is from this destining that the essence of all history [Geschichte] is determined.”

This is Heidegger’s astounding claim. The essence of technology completes metaphysics and technology has been the destiny for men and women.

The problem is that the destining of technology that unconceals all as available and standing-reserve, simultaneously conceals. The challenging nature of the essence of technology, “not only conceals a former way of revealing, bringing-forth, but it conceals

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238 Ibid., 298. The German for “standing-reserve” is Bestand. Technology perceives all things as instruments to other ends in its ability to unlock and expose, including and ultimately, human lives. This initiates an endless cycle of utility: “What is unlocked is transformed, what is transformed is stored up, what is stored up is, in turn, distributed, and what is distributed is switched about ever anew” (Ibid., 297–298).

239 Ibid., 310–11 and 315.

240 Ibid., 305–306.

241 While his grand claim is clearly implied in “The Question Concerning Technology,” Heidegger makes explicit that technology completes metaphysics in “The Letter on Humanism,” in Basic Writings: From Being and Time (1927) to The Task of Thinking (1964), 193–242. He writes, “Technology is in its essence a destiny within the history of Being and of the truth of Being, a truth that lies in oblivion. For technology does not go back to the technē of the Greeks in name only but derives historically and essentially from technē as a mode of αἰθουειν, a mode, that is, of rendering beings manifest.... As a form of truth technology is grounded in the history of metaphysics, which is itself a distinctive and up to now the only perceptible phase of the history of Being....The danger into which Europe as it has hitherto existed is...the fact above all that its thinking...is falling behind in the essential course of a dawning world destiny which nevertheless in the basic traits of its essential provenance remains European by definition. No metaphysics, whether idealistic, materialistic, or Christian, can in accord with its essence, and surely not in its own attempts to explicate itself, ‘get a hold on’ this destiny....” (Ibid., 220–221).

It must be noted that Heidegger’s relationship with Christianity, specifically his view of the Catholic Church was complicated. He maintained a positive regard for the concept of Catholicism but separated it from the institution and its doctrines, features that he rejected. His favorable regard for the concept of Catholicism may have flowed from a powerfully moving experience he encountered at a monastic liturgy. See, Safranski, Martin Heidegger, 180–181. For more on his parting with Catholicism, see also, 107–125.
revealing itself and with it that wherein unconcealment, i.e., truth comes to pass.\textsuperscript{242}

Seen in this light, the essence of technology reflects a form of reductionism. It reduces everything to immanence and eliminates beauty and transcendence.\textsuperscript{243} The challenging and deterministic characteristic of technology excludes all other forms of revealing. Beauty and nature disappear behind technology, as in the case of the power plant on the Rhine.

I do not wholly espouse Heidegger’s claim that technology completes metaphysics,\textsuperscript{244} and yet his analysis must be taken seriously. In healthcare, one can daily see how technology challenges nature. This is especially true in places like the intensive care unit, the surgical suites, and the emergency department. Ventilators, dialysis machines, and heart defibrillators make the human body appear endlessly available to life, and the essence of technology is the core problem with medicalized dying. I want to revisit the anthropological scholarship by Sharon Kaufman examined in the previous chapter because she gives concrete examples to Heidegger’s philosophical insights.

**Connecting Heidegger and Healthcare**

Heidegger argued that the essence of technology fundamentally alters nature and it does so with a power to save. Similarly, Kaufman observed “that in the hospital what is \textit{natural} is negotiable.”\textsuperscript{245} She hesitatingly concluded that the clinical procedures in

\textsuperscript{242} Heidegger, “The Question Concerning Technology,” 309.

\textsuperscript{243} Technology’s revealing, simultaneously conceals other forms of revealing that occurs through beauty and poetry. Modern technology loses the original Greek connection to human craftwork, the arts, and the poetic. Thus, it denies men and women from entering into a more original revealing or a more primal truth (Ibid.).

\textsuperscript{244} An alternative to Heidegger’s highly deterministic view of technology will come in the final section of this chapter when I explore the contribution of Albert Borgmann.

\textsuperscript{245} Kaufman, 325. Emphasis original to author.
American hospitals are fundamentally altering how contemporary men and women understand human nature. Like the power plant on the Rhine challenging the river to do things that it has never done before, medical technologies challenge men and women to hover in the gray zone between life and death. Technologies enable many patients to remain physiologically alive with minimal or no cognitive, emotional, or spiritual abilities. Prior to the technological domination in the twentieth century, the natural human experiences in such cases would have led to the patient’s death. Men and women once allowed death to emerge in their lives. Palliative care attempts to allow it to come on its own terms, in its own time. It neither hastens death, such as in the cases of PAS and euthanasia, but it also does not challenge the body to withstand death’s force. Properly conceived, palliative care allows death to emerge.

A second example of how medicine challenges human nature includes the ideas and the procedures pertaining to organ donation. This turns the human person into a manipulable body, and its organs become standing-reserve, ready for extraction and then reuse in another human body. Medical technologies provide the means to procure human organs from the dead, or in some cases from living donors, for transplantation in patients experiencing organ failure. Clinicians use technology to restart the circulatory system and provide oxygen to a body that has died, either by cardiac death or by brain death. This preserves viable organs from decay so they can be efficiently removed from the donor’s body and swiftly transported, sometimes hundreds of miles, into a recipient’s failing body. As Jeffrey Bishop provocatively commented on transplantation that someone has to die so that a dying patient can live.  

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246 Bishop, The Anticipatory Corpse, 14. Organ donation has become a hotly contested topic in medicine and bioethics. Two issues make it especially problematic. The first pertains to the methodologies
Bishop’s comment gets at the heart of Heidegger’s explanation of the essence of technology. The issue is not the technologies deployed for the procedure. Rather, the possibility of transplanting organs challenges our understanding of how we perceive one another as human beings. Someone living with liver failure temptingly views other persons as commodities. They possess a resource that he desperately needs to live. Technology reveals nature as standing-reserve, while simultaneously pushing away other considerations. This means that the man needing a liver transplant is blind to the many other realities of his potential donors. For example, he does not immediately think about this other person’s life. She may be a mother of three with aging parents who need her support while she also maintains a busy career as a leader of social service agency upon which thousands of clients rely. These other very important particularities of her life may prohibit her from the highly invasive surgery to “harvest” half of her liver so this other man might live some unknown amount of time longer. In the Catholic tradition, organ donation and transplantation are not morally objectionable in and of themselves. The problem I point to lies not in the procedure, but rather in the way the essence of technology transforms how we see others, our expectations of society, and the demands we come to make of others. For the Christian believer, it also dilutes our faith in the paschal mystery and in God’s power to bring forth life from the excruciating pain and sorrow of human death.


\[\text{Ethical and Religious Directives, §30, 63–65.}\]
These examples serve to demonstrate Heidegger’s insight regarding the essence of technology. Because it drives out other possible ways of revealing, then the ability to follow Dame Saunders’ vision of a wholly alternative way of caring for the vulnerably ill and dying becomes exceedingly difficult. This gives credence to Jeffrey Bishop’s claim that palliative care is just another form of medicalized dying.

Overcoming the dominance imposed by the essence of technology may be possible, but it is not easy. It may occur in small sectors or in remnant communities supported by faith-based healthcare. It will not happen, according to Heidegger, by confining ourselves “to a stultified compulsion to push on blindly with technology.” We cannot “curse it as the work of the devil.”\(^{248}\) We are not to become luddites. Rather, we need a different relationship to it. His insights concerning a reformulated relationship to technology remain underdeveloped and inadequate. Ultimately, he professed that “philosophy will not be able to effect an immediate transformation of the present condition of the world. Only a god can save us.”\(^{249}\) His quasi-religious endpoint has been the very ground on which Christian philosophy and the Catholic tradition have contested technology’s claim to nature and salvation.

In the following two sections of this chapter, I examine how the Christian faith and the enactment of faith in the liturgy present a way of knowing the human person that challenges the vision of nature as standing-reserve. This was the very faith that propelled


\(^{249}\) “Only a God Can Save Us: Der Spiegel’s Interview with Martin Heidegger,” trans. Maria P. Alter and John D. Caputo, *Philosophy Today* 20 (1976): 277. Technology, with its mechanization and utilitarian characteristics implicitly posits a notion of freedom and salvation as it will release men and women from their hardships, sufferings, and difficulties. Heidegger recalled that technology did not always provide an exclusive understanding of *teknē*, for the latter included beauty and the fine arts (Heidegger, 34).

Van Dijk’s analysis appears to favor Günther Anders’ vision that technology can be ethically controlled or limited by considering the persons who use it and ultimately direct it. See, Van Dijk, *Anthropology in the Age of Technology*, 121–124.
Dame Saunders to find an alternative way to medically and holistically, or “totally” care for the very sick and dying. Her unique care involved using ways of knowing her patients that did not exclusively rely on the lens of technology and efficiency. Instead, she also relied on her Christian faith.

**Part III: Christian Faith as an Engagement and Critique of Technology**

In this section I argue that the Catholic theological tradition critiques the overpowering notion of the essence of technology while not rejecting technology itself. The opening chapter described how technological advances significantly changed medicine throughout the twentieth century leading to what Ariès named as medicalized dying. Then, the discursive turn to Heideggerian philosophy provided one possible explanation concerning the intractable sway of technology, especially in medicine. The critique of technology that follows comes from an insistence that faith provides an alternative form of knowledge. It will draw from the Catholic social teaching and other similar ecclesial documents. For some readers it may seem odd to appeal to the Catholic social tradition to engage a critique of technology. One tends to think of the Catholic social tradition as concerning itself primarily with the plight of the poor and vulnerable in societies and the underlying causes of social injustices. In some respects, that is exactly the point. The essence of technology demeans nature, especially human nature. Thereby, it creates and exacerbates social injustices. As Heidegger repeatedly noted, the problem lies in the very essence of technology that reveals and also conceals essential truths. Thereby, it alters societies in ways that are nearly inescapable. In this light, then, the
Catholic social tradition provides a helpful basis on which to engage the essence of technology, because it has a deep concern for the forces that enable or disable human flourishing and virtuous living.

A close reading of several documents that comprise the corpus of Catholic social teaching reveals that they include an ongoing critical engagement with technology, particularly with regard to its impact on society. Other ecclesial documents issued by the popes throughout the last century have also contributed to a critical dialogue with technology. I would like to highlight four themes that emerge in the social tradition and other ecclesial documents: the tradition’s praise for technology, a concern for disruption and division caused by technology, a push against scientism and reductionism, and lastly, the violence of technology. My hope is that these themes will illuminate the difference between palliative care and standard medical interventions, and more importantly, bolster the claim that the Christian faith can substantially advance contemporary practices of palliative care.

The Good Fruit of Human Reason


Other papal documents contain strong social motifs such as *Deus Caritas Est* (2005), *Spe Salvi* (2007), and *Lumen Fidei* (2013), and also, *Fides et Ratio* (1998). Unless otherwise noted, all ecclesial documents and their quotations can be found online at Vatican.va.
The Catholic theological tradition praises God for the gift of creation, and it views men and women as co-creators with God. Thus, the tradition praises the advancements made by technology, particularly for the good it has advanced in societies. Technology is the fruit of human ingenuity and creativity. At a basic level, the tradition views it as a participation in God’s ongoing act of creation and a manifestation of the responsibility God gave to men and women to have dominion over the earth (Gen 1:28).

It is significant to begin with the tradition’s affirmation of technology, for as discussed above, episodes in modern history give a distinct impression that the Church eschews technological development. Pope Pius XII, although he did not write a social encyclical, reflected a fascination with science and technology throughout many of his writings that furthered an integration of the Catholic faith with the emerging sciences and their accompanying technologies. The icy rhetoric of his predecessors, concerned with rationalism and modernism, noticeably shifted. Pius XII’s writings reflect a new willingness to theologically engage dialogue not limited to faith and metaphysical reasoning, but rather faith and issues of technology. For example, he frequently opined on emerging scientific issues especially those pertaining to medicine. Many of the

252 The qualification that many, thought not all of his writings reflected a positive embrace of science and technology is not to be overlooked. Pius XII’s 1950 encyclical, *Humani Generis* stands as a glaring exception to my overall assessment. The encyclical’s subtitle “Concerning some false opinions threatening to undermine the foundations of Catholic doctrine,” admits threats that Church leaders perceived from modern scientific theories. *Humani generis* contains complex nuances as it addressed the theory of evolution and other related hypothesis on the origins of human life. Amid Pius XII’s insistent defense to preserve a role for the Divine and the human soul, he explicitly states that the Church does not forbid research and discussions regarding evolution. He understood it as an open question, and thus, some see the encyclical as supporting the necessary role of reason for science. See §36.

253 Pius XII, *The Human Body: Papal Teachings*, ed. The Monks of Solesmes (Boston: St. Paul Editions, 1960). Pius XII navigates the emerging quandaries of medical science in his day with a strong Christian anthropology. His views on the morality of medical issues can be summarized by three broad observations. First, the morality of particular medical acts ought to be based upon a full account of human nature. He envisions the physician treating more than just the patient’s physical needs, which means tending to the human person as both body and soul (“Christian Principles and the Medical Profession,” in *The Human Body*, 51–64). Pius XII insists on appealing to conscience. Both the patient and the physician
questions that Pius addressed arose because of scientific and technological advancements. In 1956, for example, the Italian Congress of Anesthesiology submitted three questions to the Holy Father regarding developing anesthetic techniques for palliating pain. His remarks reflect a detailed understanding of the complexities inherent in administering analgesics in a variety of situations, from surgery, to childbirth, and the end of life. He concludes by affirming the use of narcotics by those who are dying even if it results in decreased consciousness and shortened life. Through these dialogues technology emerges as root cause of the social forces testing the limits and necessity of faith. Thus, his successor, Pope John XXIII addressed technology in his first social encyclical, *Mater et Magistra*, 1961.


Second, Pius XII affirms the valid role of human reason for assessing the morality of medical acts. This echoes the portion from the First Vatican Council’s *Deus Filius* that protected the methodological integrity of the sciences, while also recognizing the limits of science and a patient’s autonomy. See, Pius XII, “Moral Limits of Medical Research,” chap. 28 in *The Major Addresses of Pope Pius II*, 226–234.

Third, moral medicine acknowledges a supernatural reality. It is as if Pius XII is rearticulating the concerns voiced in *Testem et Pascendi*, yet doing so with greater nuance. Pius XII states that a faith in God enables the physician to avoid potentially destructive tendencies like a purely utilitarian understanding of science and the human person. See for example, “Christian Principles and the Medical Profession,” in *The Human Body*, 51–65; and “Moral Problems in Medicine,” *The Human Body*, 311–320.


effusively imagines the “almost limitless horizons opened up by scientific research” to probe “vast hidden depths still to be explored and adequately explained.”256 His calling for the Second Vatican Council and identifying aggiornamento—an updating and opening the windows of the church—as a guiding motif, arguably represents the clearest example of his deep trust in human ingenuity and the modern world. John XXIII’s successors continue with similar, albeit much less fervent praise of technology. What I want to be clear is that the tradition does not encourage men and women to be luddites. Not only is it next to impossible to avoid technology, but it would be impractical. Even more, it would be a rejection of the gift of human reason and creativity. Despite John XXIII’s great enthusiasm, his writings reflect an unresolved tension that leads to a second observation regarding the social tradition and technology.

Division and Discord

Technology disrupts the created and social orders and divides men and women. This is particularly true when it is unrestrained, meaning that it is left to market forces and without a telos other than itself. The very opening paragraphs of the encyclical that launched the contemporary social justice tradition, Rerum Novarum “On Capital and Labor,” written by Pope Leo XIII (1878–1903) in 1891, noted how the favorable aspects of scientific discovery and technological expansion also came with unfavorable consequences.257 Technological advancements contributed to conflict between

257 Scholars agree and have identified Rerum novarum as the encyclical that inaugurated modern Catholic social teaching, meaning that it poignantly spoke to social, political, and economic issues of its day from a theological perspective and accompanied by an urgent call for actions to further the realization of justice. See, Thomas A. Shannon “Commentary on Rerum novarum (The Condition of Labor), in
employers and workers, and between the “fortunes of some few individuals, and the utter poverty of the masses.” It unnecessarily divided capital from labor, favoring the former over the latter. *Rerum novarum* observes how modern society has excised religious and supernatural dimensions of human life. In response, Leo XIII offers both socially and religiously grounded solutions to the tensions between rich and poor, and owners and workers. Among his proposals was a call to allow workers time for religious duties as work and production had become so highly emphasized.

Seven decades after Leo XIII, John XXIII noted how the divisions that once pitted the rich against and the poor and owners against workers had grown to draw sharp divisions between cultures of the world. He argued that scientific advancements must be sought in tandem with “a sincere faith in God, the Creator and Ruler of man and his world.” He described how unchecked reliance on new mechanisms can corrode the spiritual dimension of life, obscure important ancient roots of cultures, or at worst, become instruments of ruin and death.

For example, the pontiff observed, somewhat surprisingly, how medical advancements increased poverty. Modern hygiene, pharmaceutics, and clinical practices have reduced infant mortality and simultaneously increased adult life expectancy, thereby expanding the population of the poor. This is the first instance in Catholic social teaching clearly connecting technological advancement with death—a theme that receives greater attention in the latter part of the century.


260 *Mater et magistra*, §209.

261 *Mater et magistra*, §176, 198.

262 *Mater et magistra*, §187.
For John XXII, the church, acting like a mother, plays an integral role in restoring global equilibrium because faith orders and forms human conscience. Without formed consciences, scientific advancements run askew from ameliorating social and global disparities. This assertion that the church provides something necessary to restore a greater sense of social justice echoes ideas from *Rerum novarum*. There, Leo XIII elaborated on how the church makes important contributions to the fabric of living societies that reason and technology alone do not. It views men and women not merely as a means to greater production, to higher profitability, or to advancement and development. Rather, in the eyes of the church, men and women possess their own dignity, gifts, and God-given talents. Faith in Jesus Christ reaches to the innermost minds and hearts of men and women so that they may “act from a motive of duty, to control their passions and appetites, to love God and their fellow men with a love that is outstanding and of the highest degree and to break down courageously every barrier which blocks the way to virtue.” Healing for the brokenness experienced by social forces and disparity flows from the Christian life and Christian institutions. With Christ at the center, the Christian faith stands as “the first cause and the final end; as from Him all came, so to Him was all to be brought back.” By asserting Christ as the final end or *telos*, *Rerum novarum* implicitly directs all work—scientific, service, pastoral, or otherwise—toward Christ and the Reign of God.

*Gaudium et Spes*, the Second Vatican Council’s Pastoral Constitution on the Church, reflects the tension that praises technology while also grappling with its

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263 *Mater et magistra*, §212.
265 *Rerum novarum*, §27.
unintended ill effects.\textsuperscript{266} For example, it affirms the legitimate autonomy of not only the sciences, but of culture and politics as well. It calls Christian men and women to read the signs of the times, to lift up the good that they find, as well as proclaim the good news to those places and aspects of the society that experience injustice and the brokenness wrought by sin. \textit{Gaudium et spes} implicitly recognized the divisions caused by science and technology. This is evidenced in its call for theologians to explore “more suitable ways” of connecting doctrine to other disciplines and for pastoral workers to embrace psychology, sociology, and other secular sciences so that the faithful may mature in their faith life.\textsuperscript{267}

Throughout the long pontificate of John Paul II, his writings consistently relied upon a methodology of personalism, meaning that the subjective dimension of human nature must remain primary to all human activity. Through this lens he confronted modernity’s dualism by describing a vision of how men and women flourish when there is a unity between faith and reason. Such unity includes all of the many offshoots of reason in contemporary philosophy.\textsuperscript{268} Although not a social encyclical, the opening line

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\textsuperscript{266} Joseph Ratzinger, prior to becoming Pope Benedict XVI, suggested that reading \textit{Gaudium et Spes} from this macro view may be wrongheaded. See Tracey Rowland, \textit{Ratzinger’s Faith: The Theology of Pope Benedict XVI} (New York: Oxford University Press, 2008), 150–152. David Hollenbach has an excellent analysis of the tension that runs through \textit{Gaudium et spes}. He addresses the related themes of faith and reason, universality and particularity, and the role of dialogue. See his “Commentary on \textit{Gaudium et spes}: Pastoral Constitution on the Church in the Modern World,” in \textit{Modern Catholic Social Teaching}, 266–291, especially 271–279.

\textsuperscript{267} \textit{Gaudium et spes: Pastoral Constitution on the Church in the Modern World}, 7 December 1965, §62.

\textsuperscript{268} John Paul II delineates multiple expressions of reason in the contemporary intellectual life. This multiplicity increases the complexity and difficulty in arriving at a unified vision of knowledge. He writes, “the segmentation of knowledge, with its splintered approach to truth and consequent fragmentation of meaning, keeps people today from coming to an interior unity. How could the Church not be concerned by this?” (\textit{Fides et Ratio: On the Relationship Between Faith and Reason}, 15 September 1998, §85). He singled out eclecticism, historicism, modernism, postmodernism, pragmatism, nihilism, and scientism (Ibid., §86–91). All of them suffer without the voice of faith. Where theology once dialogueed directly with metaphysics as its interlocutor regarding reason, it now has a plurality of disciplines related to reason. A helpful discussion on a range of metaphysics operative in Catholic ecclesial documents throughout the twentieth century can be found in Thomas G. Guarino, \textit{Foundations of Systematic Theology} (New York:
of *Fides et Ratio* captures a helpful image: “Faith and reason are like two wings on which the human spirit rises to the contemplation of truth… [B]y knowing and loving God, men and women may also come to the fullness of truth about themselves.” This personalism acts like a rudder that steers his praises, critiques, and insights regarding technology. It also retains the traditional view of the person as having an earthly and supernatural dimension in addition to envisioning men and women as living in community. Humane development must enhance the lives of men and women, enabling them to fulfill their personal vocation and calling from God. John Paul II seemed well aware of Heidegger’s observation that the essence of technology views all of nature as immanent. Against this backdrop, John Paul II insists, “the apex of development is the exercise of the right and duty to seek God, to know him and to live in accordance with that knowledge.” Genuine solutions to the pressing social questions will not be found apart from the Gospel. At stake is a distortion of the inner essence of things and a malaise with regard to the transcendent dimension to the human person.

**Scienticism and Reductionism**

T&T Clark International, 2005), 39–82. Alasdair C. MacIntyre’s *Whose Justice? Which rationality?* (Notre Dame, IN: University of Notre Dame Press, 1988), argues that there is no one, universal act of rationality. It depends upon a particular tradition of reasoning and one’s ability to understand and embody that tradition, as well as incorporate and anticipate the perspectives of that tradition’s rivals.

269 *Fides et ratio*, Introduction.


271 *Centesimus annus*, §29.

272 Ibid., § 5, 55. The Congregation for the Doctrine of the Faith emphasized the transcendence of the human person in the face of biomedical research and technologies involved in the creation of unique human life. Under the title *Donum Vitae*, the document engages science and technology and asserts Christian anthropological concepts such as technology must serve human persons, science needs the human conscience, and the human body cannot be envisioned without the soul. See, *Donum Vitae: Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day*, issued by Prefect Joseph Card. Ratzinger, 22 February 1987.
A third characteristic of technology articulated in the Catholic tradition emerges in *Gaudium et spes*. Reflecting on the signs of the times, the Council’s participants noted how scientific and technological reasoning has significantly influenced global change and has prevailed as the primary, if not all but exclusive mechanism used by global leaders to address matters of human development.273 The Council states, “intellectual formation is ever increasingly based on the mathematical and natural sciences and on those dealing with man himself, while in the practical order the technology which stems from these sciences takes on mounting importance.”274 *Gaudium et spes* pinned science as a new, primary, and dominant mode of reasoning,275 recognizing that the cultural and social shift embracing technology has affected how people think about themselves and their relationship to creation. This new mode implicated technology as science and technology are mutually dependent.276

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273 This signals a nuanced changed from the First Vatican Council (1869–1870) that eight decades prior in *Dei Filius: The Dogmatic Constitution on the Catholic Faith*, 24 April 1870, had identified rationalism as a threat to faith. It also identified fideism as a threat to reason, as the Council argued for balance between faith and reason, thus recognizing the indispensable necessity of each. See, *Dei Filius*, Ch. 4 “On Faith and Reason,” and the Canons. *Gaudium et spes* talks much less about the generic category of rationalism and more specifically about science and technology.

274 *Gaudium et spes*, §5.

275 Avery Dulles contends that the strong rationalism that influenced the mid-to-late nineteenth century faded as the twentieth century progressed. He describes that a prevailing mood since the close of the twentieth century has been a metaphysical agnosticism, yet a remnant of rationalism remains—scientism. Avery Dulles, “Faith and Reason: From Vatican I to John Paul II,” in *The Two Wings of Catholic Thought: Essays on Fides et Ratio*, ed. David Ruel Foster and Joseph W. Koterski (Washington, DC: The Catholic University of American Press, 2003), 196, among 193–209. Beyond *Gaudium et spes*, other conciliar documents referenced the more traditional dialect between faith and reason, such as *Gravissimum Educationis: The Declaration on Christian Education*, §10; *Dignitatis Humanae: The Declaration on Religious Liberty*, §3; *Nostra Aetate: The Declaration on the Relation of the Church to Non-Christian Religions*, §2; *Dei Verbum: The Dogmatic Constitution on Divine Revelation*, §2 and §6. See Glenn B. Siniscalchi, “Knowing that God Exists: Retrieving the Teaching of *Dei Filius*,” *American Theological Inquiry*, (Online), 3 no. 2 (July 15, 2010): 45–68, especially p. 62.

276 Scholars debate whether technology gave rise to modern mathematical science, or whether technology is the result and practical application of the latter. Heidegger claimed the primacy of technology. He explains, “Chronologically speaking, modern physical science begins in the seventeenth century. In contrast, machine-power technology develops only in the second half of the eighteenth century. But modern technology, which for chronological reckoning is the later, is, from the point of view of the essence hold sway within it, historically earlier” (*Heidegger, Basic Writings*, 304).
Pius XII had also expressed a concern about a “technological spirit” diminishing the human soul. The Council voiced stronger concerns, saying “this scientific spirit has a new kind of impact on...modes of thought. Technology is now transforming the face of the earth, and is already trying to master outer space.” Today, a half-century after the Council, the signs of the times indicate no slowing in technology’s quest to expose and transform unknown frontiers as scientists now aim to map the neural connections of the human brain.

Similar to Heidegger’s observations, Gaudium et spes recognizes that the essence of technology has penetrated into the ways that men and women think about nature and the world. Thus, the Pastoral Constitution calls for new theological analysis and synthesis. It cautions those who “look forward to a genuine and total emancipation of humanity wrought solely by human effort: they are convinced that the future rule of man

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Others have objected, arguing that science does not necessarily reduce objects to instrumental means and mere standing-reserve. Human virtue can foster a humanization and well-being in which science can participate. See, John O’Neill, Ecology, Policy, and Politics: Human Well-Being and the Natural World, (London: Routledge, 1993).

Albert Borgmann describes how “scientific knowledge is a necessary condition of modern technology; it is not however, sufficient. The question remains of how technology acts on the transformative possibilities provided by science and the description of the character of technology is a task in its own right.” See, Technology and the Character of Contemporary Life, 31; and more extensively see 17–32.

Pius XII’s openness to technology came paired with skepticism and disapproval for an emerging “technological spirit.” He described this as a “grave spiritual danger,” as it gives an illusion of self-sufficiency, reinforces absolute human confidence, and approximates the Infinite Itself. Pius XII expressed concern that mechanical production would replace human effort and work. The “technological spirit” could lead the human mind away from the works of God and the mysteries of faith. Moreover, if taken to an extreme, it could severely diminish the human person at the expense of the soul. The Major Addresses of Pope Pius XII Volume II: Christmas Messages, ed. Vincent A. Yzermans (St. Paul, MN: The North Central Publishing Company, 1961), 23–26.

Gaudium et spes, §5.


Gaudium et spes, §§5, 7.
over the earth will satisfy every desire of his heart.”

The search for freedom that relies on the result of scientific and technological progress can “foster a certain exclusive emphasis on observable data, and an agnosticism about everything else. For the methods of investigation which these sciences use can be wrongly considered as the supreme rule of seeking the whole truth.” This eloquently restates Heidegger’s claim that the essence of technology reveals while also concealing truth. Technology and scientific inquiry do reveal aspects of truth, and to that, Gaudium et spes asserts the tradition’s perspective that faith also reveals truths that technology alone cannot grasp.

Following the Second Vatican Council, Pope Paul VI (1963–1978) elaborated extensively on the gross imbalances in human progress across the world, most notably in his 1967 encyclical Populorum Progressio. He echoes his predecessor’s observation that modern advancements have exacerbated global disparities. He pleads for progress and development to reduce inequalities, eliminate discrimination, give men and women the capacity for self-improvement, while also furthering their moral and spiritual growth.

Critiquing mere methods of redistribution does not adequately address the root problem—technology. He writes:

It is not enough to increase the general fund of wealth and then distribute it more fairly. It is not enough to develop technology so that the earth may become a more suitable living place for human beings. The mistakes of those who led the way should help those now on the road to development to avoid certain dangers. The reign of technology—technocracy, as it is called—can cause as much harm to the world of tomorrow as liberalism did to the world of yesteryear. Economics and technology are meaningless if they do not benefit man, for it is he they are to serve.

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281 Ibid., §10
282 Ibid., §57.
284 Populorum progressio, §34.
Once again, this vignette from the social tradition asserts a supernatural dimension and humanity’s divine destiny over and against technology’s reductionistic efforts to obscure this reality. Authentic development must admit a spiritual dimension and a Divine Creator toward which all human activities are directed. Thus, Paul VI urges the faithful to cultivate wisdom, not just technological savvy. The latter arises from the reasoning of the intellect while the former flows from friendship, love, prayer, and contemplation. Paul VI concludes by admonishing progress for its own sake, for personal gain, or for comfort. Instead, progress, or more specifically technology ought to benefit the welfare of all people.

The pervasiveness of scientism and a technological spirit within developing societies continued as a source of theological concern in the final years of the twentieth century. John Paul II grasps the deep interconnections between science and technology. Together they have manifested radical changes in societies where future possibilities appear boundless. When scientific inquiry abandons dialogue with other philosophies, especially religiously inspired philosophical traditions that question the meaning of life, then:

285 See for example §14, where the pontiff quotes the French Dominican social scientist Louis-Joseph Lebret, who advocates for the centrality of men and women, to whom economics and development ought to be directed. Pope Paul VI follows this in §16 with an explanation that men and women are ordered to a supernatural dimension, as God is “the first truth and the highest good.” Human life is enhanced when men and women unite with Christ. Their lives acquire “a transcendent humanism which surpasses its nature and bestows new fullness of life. This is the hugest goal of human self-fulfillment.” In §42, Paul VI describes true humanism as pointing toward God and acknowledging a deep and real meaning to human life. Allen Figueroa Deck describes the encyclical’s methodology as a transcendental humanism. See, “Commentary on Populorum progressio (On the Development of Peoples)” in Modern Catholic Social Teaching, 292–293.

286 Populorum progressio, §20. In §75, Paul asserts the need for prayer and action, and §81 urges that transformations be permeated with the spirit of the Gospel. See also Gaudium et spes §15 which similarly references the need for wisdom to perfect the intellect.

287 Populorum progressio, §86.

288 He identifies scientism as “the philosophical notion which refuses to admit the validity of forms of knowledge other than those of the positive sciences; and it relegates religious, theological, ethical and aesthetic knowledge to the realm of mere fantasy” (Fides et ratio, §88).
This leads to the impoverishment of human thought, which no longer addresses the ultimate problems which the human being, as the animal rationale, has pondered constantly from the beginning of time. And since it leaves no space for the critique offered by ethical judgment, the scientistic mentality has succeeded in leading many to think that if something is technically possible it is therefore morally admissible.  

Not unlike Francis Bacon’s admonition over four hundred years ago, John Paul II urges the pursuit of scientific efforts to unfold within a sapiential horizon, because the search for truth “is never ending but always points beyond to something higher than the immediate object of study, to the questions which give access to Mystery.” Because technology appears to have boundless limits and possibilities, it all the more needs the benefit of ultimate values and direction, lest it spiral into total destruction. Faith provides science with a direction, and together the two tend toward God, the Creator and source of all truth.

The Violence of Technology

Lastly, Catholic social teaching voices concerns about violence unleashed by technology’s boundless limits and possibilities. As much as John XXIII favored the promise of technology, he also observed that “these gigantic forces for good can be

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289 Fides et ratio, §88.
290 Fides et ratio, §106. See also §69 where John Paul affirms the role of scientific inquiry. “Reference to the sciences is often helpful, allowing as it does a more thorough knowledge of the subject under study.” Nevertheless he cautions against a narrow focus and explains how a diversity of methodologies can unify not only two interlocutors, but even cultures. He writes that scientific inquiry should not “mean the rejection of a typically philosophical and critical thinking which is concerned with the universal. Indeed, this kind of thinking is required for a fruitful exchange between cultures. What I wish to emphasize is the duty to go beyond the particular and concrete, lest the prime task of demonstrating the universality of faith’s content be abandoned. Nor should it be forgotten that the specific contribution of philosophical enquiry enables us to discern in different world-views and different cultures ‘not what people think but what the objective truth is.’”
291 Fides et ratio, §81
turned by science into engines of destruction.”

Viewing all of creation as flowing from God can prevent science and technology from arcing toward destruction. John XXIII observed that “separated from God a man is but a monster, in himself and toward others.”

The experience of two world wars and the gruesome memory of nuclear destruction temper this pope’s penchant to praise the new. In his encyclical on peace, John XIII admits the “ghastly and catastrophic consequences” that are possible with modern technology.

Paul VI decried the “omnipresent ideology” of efficiency and the illusion of science and technology to sustain “indefinite progress” in his Apostolic Exhortation Octagesima Adveniens. The illusion of limitless possibilities brought about by human ingenuity degrades human relationships as scientific and technological advancements have created a new positivism. It is prone to manipulating men and women, impacting their desires, reducing them to efficient and quantitative presuppositions, and, even influencing their values. He notes that the sciences “are a condition at once indispensable and inadequate for a better discovery of what is human.”

The reductionism of the complexity and beauty of being human fails, as Paul VI says, to “provide the complete and definitive answer to the desire which springs from [one’s]...”

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293 Ibid., §215.
294 The horrors and violence of the world wars also profoundly impacted the fervor of philosophers to address technology, including the thinkers previously noted: Jünger, Anders, Huxley, and Heidegger among numerous others.
297 Ibid., §39.
298 Ibid., §40
innermost being.” Popes John XXIII and Paul VI began using strong language to delineate the moral limits of technology, and at the end of the twentieth century John Paul II unleashed even stronger criticism.

John Paul II coined and popularized the term, “culture of death.” He refers to it in his social encyclical Centesimus Annus. However, he most fully treats it in his 1995 encyclical Evangelium Vitae: On the Value and Inviolability of Human Life. Although the encyclical is not part of the corpus of social teaching, it unmistakably speaks to social issues. It describes how the advancements of science and technology have affected morality and thereby contributed to the emergence of a “culture of death.” This culture has perpetuated a “war of the powerful against the weak;” it denies solidarity with the vulnerable and less favored, views burdens as intolerable, resists or altogether eliminates any hint of compromised well-being or handicap, and even conspires against life. The technological and scientific way of thinking has created a worldview whereby the role of men and women is to program, control, and dominate. As noted earlier, Sharon Kaufman described the confusion about palliative care in American hospitals, in part because the clinical pathways not only control, but even time the dying experience. Similarly, the pontiff explains how primordial human experiences such as birth and death, “instead of being primary experiences demanding to be ‘lived’, become things to be merely ‘possessed’ or ‘rejected.’” John Paul II urges the Christian faithful to foster a “new culture of human life,” where such fundamental aspects of our human nature, such as physical decline and eventual death can be lived rather than rejected.

299 Ibid., §40
300 Ibid., §39.
301 John Paul II, Evangelium Vitae: On the Value and Inviolability of Human Life, 25 March 1995, §12, emphasis added; See also §64.
302 Evangelium vitae, §22.
Efforts to move in this more natural and life-giving direction must include that cultivation of communal prayer and spiritual practices. He explains:

We are called to express wonder and gratitude for the gift of life...above all in the celebrations of the liturgical year. Particularly important in this regard are the Sacraments, the efficacious signs of the presence and saving action of the Lord Jesus in Christian life. The Sacraments make us sharers in divine life, and provide the spiritual strength necessary to experience life, suffering and death in their fullest meaning. Thanks to a genuine rediscovery and a better appreciation of the significance of these rites, our liturgical celebrations, especially celebrations of the Sacraments, will be ever more capable of expressing the full truth about birth, life, suffering and death, and will help us to live these moments as a participation in the Paschal Mystery of the Crucified and Risen Christ.\footnote{Evangelium vitae, §84.}

At the end of an encyclical expounding on the inviolable dignity of human life, John Paul II calls upon the Christian faithful to engage the Christian sacraments. He appeals to the liturgical rites reformed by the Second Vatican Council, perhaps due to the Council’s call for the full, active, and conscious participation of the faithful. The passage suggests that the sacraments provide the worshippers the strength to resist the totalizing tendencies of the essence of technology. As the pontiff notes, participation in the sacraments engenders a fuller experience of the paschal mystery. This simple, yet powerful statement asserts that encountering the paschal mystery through the sacraments strengthens men and women to face human suffering and death with the faith and hope of Christ. This was the key insight of Dame Saunders, and I will expand upon the connection of the sacrament and palliative care in the next chapter.

More immediately, it is important to note that this is the first instance where the Catholic tradition in modern times, expressly links the sacramental life of the church with cultural change. It reflects an emerging methodology that integrates various aspects of the life of the church—the sacramental-liturgical life with matters of social justice. John
Paul II’s successor, Pope Benedict XVI (2005–2013) also employs this methodology. He explicitly connects sacraments to virtue, ethics, and social change.

Pope Benedict XVI – A Displaced Faith in Progress

Three of Pope Benedict XVI’s encyclicals bring my considerations on faith and technology up to date. I will first highlight passages from his encyclical on hope, *Spe Salvi*, followed by a very limited analysis of his social encyclical *Caritas in Veritate*. Lastly, I draw out key passages from the encyclical he co-authored with his successor, Pope Francis (2013–present).

In *Spe salvi*, Benedict XVI observes how technology offers a misguided understanding of redemption. The German pontiff describes how Bacon’s triumphal conviction of human dominion over creation sowed the seeds in the scientific mind that it would redeem human nature. Faith was not altogether denied, but rather displaced “onto another level—that of purely private and other-worldly affairs—and at the same time it [became] somehow irrelevant for the world.” In other words, the Baconian project distorted faith, positing it as “faith in progress,” rather than faith in a transcendent God and Creator. This in turn impacted centralizing ideas of reason and freedom. The

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304 The first two encyclicals, *Spe Salvi* and *Caritas in Veritate* come under his own name. Benedict XVI, *Spe Salvi: On Christian Hope*, 30 November 2007; Benedict XVI, *Caritas in Veritate: On Integral Human Development in Charity and Truth*, 29 June 2009. The third, *Lumen Fidei: On Faith*, 29 June 2013, comes under the name of Benedict XVI’s successor Francis, who clearly notes in the opening paragraphs that the Emeritus Pope had begun the work prior to resigning from office. Many commentators note that much of the work resembles the style of Pope Benedict XVI. Francis issued the encyclical, and thus, references to passages and quotations will come under his name.

305 In addition to the encyclicals, other aspects of Benedict’s thought on faith and reason have been compiled in *A Reason Open to God: On Universities, Education, and Culture*, ed. J. Stephen Brown (Washington, DC: The Catholic University of America Press, 2013).

306 *Spe salvi*, §17.

307 Ibid., §17.
essence of technology views freedom as disburdenment, or in Benedict XVI’s words, “the overcoming of all forms of dependence—it is progress towards perfect freedom. Likewise, freedom is seen purely as a promise, in which man becomes more and more fully himself.”

Benedict XVI asserts that technical progress must be matched by corresponding progress in human ethical formation lest the progress become a threat for men and women and the whole world. Technology and reason need the gift of faith to cultivate moral growth that differentiates between good and evil. Faith likewise needs the balance of reason. Benedict XVI restates a fundamental aspect of the tradition that upholds the coinhereince of faith and reason. When reason effectively serves faith, it preserves faith from two extremes: on the one hand outright exclusion, and on the other fundamentalism. Both faith and reason need to allow the nature of the other to flourish and to fulfill their mission and to render a more loving society.

The final chapter of Benedict XVI’s social encyclical, Caritas in veritate, squarely addresses technology. Key for Benedict XVI and the larger Catholic tradition is the subjective dimension, namely that men and women must remain primary.

The pontiff’s explanation reflects striking similarities to Heidegger. The pope states, “technology is never merely technology. It reveals man and his aspirations toward development, it expresses the inner dimension that impels him gradually to overcome

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308 Ibid., §18.
309 Ibid., §22. Benedict traces how progress grew out of the sciences to also include politics. As an example, one can see the evolution in the movement from the sling to the atom bomb, which he describes as “terrifying progress in evil.” Progress in the wrong hands and devoid of faith becomes threatening to all.
310 Caritas in veritate, §57. Both extremes exclude fruitful dialogue. See, §56.
311 This theme runs all throughout Catholic social teaching. A more comprehensive analysis is beyond the scope of this present work. This subjective dimension grounds the epistemology operative in John Paul II’s social encyclical Laborem exercens, especially §5. Not unlike Bacon, Benedict views technology as an aspect of God’s command to the first human beings to embrace their dominion over creation.
material limitations. *Technology, in this sense, is a response to God’s command to till and keep the land (cf. Gen 2:15).*”  
He suggests technology should ultimately help men and women flourish in ways that God intended. When properly ordered, technology ought to help societies transcend material limitations, rather than seek to dominate nature and confine it to standing-reserve.

Every day in hospitals and clinics one can see the imbalance created by a disordered relationship between technology and clinical care. Often at the beginning of a disease or a chronic condition a patient begins to use simple prescriptions or an assisting medical device. The goal, initially, is to keep the patient as fully functioning or mobile. As the disease progresses, healthcare professionals and patients alike, neglect to review the overall goals of care. Not uncommonly the goal changes. It happens either implicitly or explicitly, and it frequently occurs with a change in attending physicians or during a transfer of the location of care. Imperceptibly technology becomes the driving force to overcome the disease with an escalating use of medications and devices. Somewhere along the path of time in the disease progression, the living person has been lost in the list of medications prescribed.

This reality worries Benedict XVI. He sees biotechnology as overly influenced by the “culture of death.” He observes how the materialistic and mechanistic views of the person have proliferated to the point where emotions and the interior life are seen from “a purely psychological point of view, even to the point of neurological reductionism.” Like his twentieth-century predecessors, Benedict XVI describes that authentic human development is closely bound up with the human soul and conscience.

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312 Caritas in veritate, §69. Emphasis original to Benedict.  
313 Ibid., §76.
It needs the natural and the supernatural, the embodied self and the *imago Dei*, the scientific and the faithful. When thoughtfully balanced, these dialectical components can foster a holistic development that promotes the common good.

The pontiff urges critical reflection upon the purposes and the means of development. He explains that when technology merely follows whatever is efficient and utile and fails to serve human needs, development is denied. He writes “true development does not consist primarily in ‘doing.’ The key to development is a mind capable of thinking in technological terms and grasping the fully human meaning of human activities, within the context of the holistic meaning of the individual’s being.”

Technology’s attractiveness flows from its ability to draw the human mind to broader horizons. But, Benedict emphasizes, “*human freedom is authentic only when it responds to the fascination of technology with decisions that are the fruit of moral responsibility.*” Benedict calls for deep reflection on the temptation to emphasize total autonomy, and he asserts that “*development is impossible without upright men and women, without financiers and politicians whose consciences are finely attuned to the requirements of the common good.*” For Benedict, prayer is essential to the formation of conscience.

At the conclusion of both, *Spe salvi* and *Caritas in veritate*, the pope urges the faithful to engage in prayer. This turn to prayer reflects Benedict’s insistence that that faith not be reduced to intellectual information. The Christian message must also be

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314 Ibid., §70.
315 Ibid. Emphasis original to the Pope.
316 Ibid., §71. Emphasis original to the Pope.
317 *Spe salvi*, 32–34; *Caritas in veritate*, 79.
performative. Faith is gift from God and for millennia, the mark of the Christian community has been their celebration of faith. It is clear that for Benedict, prayer necessarily involves the liturgy. He specifically evoked the sacraments in his encyclicals, a detail that carried over in his final encyclical *Lumen Fidei*.

**Faith as Light and Sacrament**

From the very beginning of the encyclical, *Lumen fidei* links the luminous light of faith with Christ who gives the gift of eternal life in baptism. The radiance of this faith leads the believer on a path that ultimately penetrates the darkness of death. This opening image presents a counterpoint to Heidegger’s observation that the essence of technology conceals all other ways of revealing. Technology’s promise to extend life and save men and women from sickness and death is met by faith in Christ Jesus, the incarnate Word of God, who provides the light to “illumine the origin and end of life.”

From this perspective, *Lumen fidei* revisits afresh the interplay of faith with science and technology.

In *Lumen fidei* Francis articulates the characteristics of technology in familiar terms. Truth, he says, is determined by “what works and what makes life easier and more comfortable. Nowadays this appears as the only truth that is certain….the only truth that can serve as a basis for discussion or for common undertakings.” Like the tradition that I have recounted throughout this chapter, Francis too, insists that the truth arising from reason, science, and technology, is one valid and important way of knowing. Just as

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318 *Spe salvi*, §2.
319 Pope Benedict, when he was a Cardinal, had described prayer in terms of liturgy. See, Joseph Ratzinger, *The Spirit of the Liturgy* (San Francisco: Ignatius Press, 2000). See also *Spe salvi*, §§10, 34
320 *Lumen fidei*, §21.
321 Ibid., §25.
two eyes help an individual see more clearly, so too does faith assist the empirical. As Lumen fidei evermore sustains a Christian counterpoint to technology, it moves beyond simple restatements of past doctrine. Two unique theological insights merit attention.

First, it introduces love as the guide toward truth. Guided by love, faith “can penetrate to the heart, to the personal core of each man and woman. Clearly, then, faith is not intransigent, but grows in respectful coexistence with others… Far from making us inflexible, the security of faith sets us on a journey; it enables witness and dialogue with all.”322 Such dialogue necessarily entails the science and technological patterns in society.

This type of dialogue inspired the origins of palliative care and has enabled the development of this alternative approach to medical practice with persons experiencing chronic and terminal conditions. For example, a faith born of love, illumines the reality of human suffering. It can give meaning to suffering, especially emotional, social, and spiritual sufferings immune from medical therapies.323 When faith is understood as a memoria futuri—grounded in the trust of God’s past promise of faithful abiding illuminating the way forward—then it holds the possibility that faith can illumine the deepest darkness of suffering and death.324 Stated differently, unlike the aims of technology that makes a promise of disburdenment, “faith does not make us forget the sufferings of the world.”325 Rather it draws men and women closer to the suffering. In the scriptures God comes close to the suffering and provides not answers, but accompaniment. This is seen most clearly in the person of Christ who shares in human suffering and whose resurrection opens up a ray of light. This image comes alive in the

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322 Ibid., §34.
324 Lumen fidei, §56.
325 Ibid., §57.
sacraments that celebrate the paschal mystery. Perhaps for this reason, this most recent encyclical on faith adds ecclesial and explicitly sacramental examples.

A second theological insight from Lumen fidei emphasizes that faith has an ecclesial dimension. The Christian faith that draws believers closer to the sufferings of others witnesses to the fact that faith is never merely an individual decision. Israel’s faith in YHWH found its place in community. In much the same way, Christian baptism, which initiates the gift of faith in the individual, takes place within a community of believers.\(^{326}\) Baptism initiates infants, women, and men into the journey of discipleship with the Risen Lord and leads towards the banquet of the eucharist. Francis echoes a central piece of Sacrosanctum concilium when he states, “the sacramental character of faith finds its highest expression in the Eucharist.”\(^{327}\) The Eucharist affirms the communal and dimension of faith.\(^{328}\) It simultaneously reveals to the worshipping body their dependence on both, one another and God.

This connection to Eucharist is important because one grows in the theological virtues by gifts of God’s grace. The following chapter will examine sacraments as encounters with God’s divine gifts. The point to be made here is that the tradition no longer merely asserts that faith must be a part of scientific inquiry and an essential component to appropriately curtail technology. Instead, these ecclesial documents more specifically insist on the participation in the life of faith, this participation must include the sacraments.

\(^{326}\) Ibid., §14, 22, 39, 40, 41.
\(^{327}\) Ibid., §44.
\(^{328}\) Richard R. Gaillardetz explains the ecclesiological connections to the social justice tradition in “The Ecclesiological Foundations of Modern Catholic Social Teaching,” in Modern Catholic Social Teaching, 72–98.
What is important is how Catholic social teaching and other related ecclesial documents reveal a sustaining voice that insists on placing faith alongside technology. The pontiffs can make these claims and connections because their vision of the mutual compatibility of faith and technology arises out of a Christian anthropology. In other words, faith views nature differently than technology—beginning with human nature. Technology views human persons as standing-reserve, but the Christian tradition views men and women as possessing an inviolable dignity and creatures who need and depend upon one another, and ultimately, as creature—body and soul—destined for divinization. Examining each of these characteristics of a Christian anthropology will tie together the views of faith, technology, and liturgy.

**Christian Anthropology**

**Human Dignity**

Dignity, understood as the intrinsic and inviolable worth of all human life, stands as the bedrock of a Christian anthropology. It runs as a continual theme throughout the social justice tradition. Every instance of unique human life possesses an inestimable worth, and therefore it beckons all other members of society to not only respect that life but also commit to do whatever is necessary for human life to flourish. The understanding of intrinsic human dignity flows from a theological view of creation, [329](#) The very beginnings of modern Catholic social teaching, *Rerum novarum*, asserted the nonnegotiable dignity of human beings against the repugnant working conditions laborers experienced. See *Rerum novarum*, §§ 20, 36, 40. The theme continues throughout the social justice tradition. This dignity becomes the grounding for John XXIII’s call for human rights, including the right to medical care and to be looked after in times of ill health, disability, and old age. See, *Pacem in terris*, §11. Dignity anchors John Paul II’s personalism and the argument for a culture of life as discussed earlier. Additionally, it becomes a cornerstone for Pope Benedict XVI’s vision of *caritas* and the right to palliative care, which will be discussed later in this work.
whereby God created men and women in God’s own image and likeness (Gen 1:26). Every human life, in some regard, bears a unique image of God, the *imago Dei*. The event of the Incarnation, God becoming flesh (John 1:14), confirms and intensifies the understanding that human life images God’s own life. Jesus as God in flesh, fully human and fully divine as the early ecumenical councils discerned and taught, reveals the pattern of full and authentic Christian living.

Susan Ross highlights three important implications for seeing Jesus as the epitome of the *imago Dei*. First, Jesus emulates Christian living in all of its many varied forms, primarily in his self-sacrificing love that led to his death. Ross comments, “Somehow, Jesus is always at the center of a Christian theological anthropology; who he is suggests who we ought to be.”

Second, she notes that Jesus reveals a right relationship with God. The depth of openness, the dependence, and the commitment to the unseen God witnesses the necessary elements for a flourishing spiritual life. Third, and especially important for the considerations herein on medicine and palliative care, Jesus models a right relationship with the culture and the world around him. Jesus embraced the world in which he lived and at the same time, he criticized and sought to reform cultural norms.

This chapter has highlighted the pervasiveness of science and technology in contemporary American culture, and I have raised some critiques of that reality. This is not to say that good does not also flow from this reality. I share Ross’ reflections on the *imago Dei* whereby she says, “scientific analyses of the human contribute to an ever-

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330 Susan A. Ross, *Anthropology: Seeking Light and Beauty* (Collegeville, Minn: Liturgical Press, 2012), 11. She is careful to note the problems associated with the atonement interpretations of Christian soteriology, especially as it relates to matters of particular import for feminists.
331 Ibid., 12.
richer picture of our complexity and our relationship with the rest of creation… While the sciences can enrich our knowledge of ourselves and of the world around us considerably, theology…can ask questions of meaning and truth that go beyond scientists’ purview.”

This view of men and women imprinted with the *imago Dei* permeates the social justice tradition, and it serves as a basis for our participation in worship. The living presence of God in us meets the real, living presence of God revealed in the liturgy and sacraments.

*Embodiment*

A second characteristic of Christian anthropology is embodiment. It bears intimate connections to the incarnation, and it is implied in the *imago Dei*. Margaret Farley expresses concern over a body-spirit dualism plaguing modernity and world religions as well. She describes how a move by the early feminists that critically rejected the association of bodies with women, paradoxically freed women to “‘reclaim’ their bodies—to claim them as their own, as integral to their selfhood and their womanhood.” This has encouraged wider circles of theologians to ponder and understand what it means to *be* a body and to *have* a body, and therefore reinterpret, if not avoid, the modernist view of bodies as objects. Because the eternal Word of God took on human flesh, then our human bodies have tremendous significance.

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332 Ibid., 139.
333 Margaret Farley, “Feminist Theology and Bioethics,” in *On Moral Medicine*, edited by Stephen E. Lammers and Allen Verhey, 2nd ed., (Grand Rapids, MI: William B. Eerdmans Publishing Company, 1998) 94. She observes how the historic association of women with the body and men with the mind has long contributed to a negative view of the human body, one that both Judaism and Christianity have not escaped. Farley notes that in late-antiquity, Near Eastern gnosticism, which rejects the body in favor of higher forms of pure knowledge as the path to salvation, along with world-denying attitudes prevalent in mysticism influenced Judaism. They also impacted Christianity, as did Greek philosophical distrust of the impermanence and transitory nature of human bodies.
334 Ibid., 95.
335 Ibid., 95.
Farley has also argued that these nuances and differences affect individual experiences of medical care. Differences in how one understands bodilyness impacts the physician-patient relationship. “It makes a difference,” Farley observes, “whether bodies are objects to be fixed or embodied persons who present certain needs. It makes a difference to the meaning of disease and of disability what reigning model is of the ‘perfect’ body. And suffering, bodied suffering, though without its own language, nonetheless receives meaning that determines our response.”

As seen in the first chapter, Jeffrey Bishop contends that most of medicine tacitly views the corpse as the perfect body primarily because it can be manipulated and controlled. Farley ascribes the movement to reclaim a positive notion of bodilyness to feminists. Dame Saunders, as a female physician—regardless of whether or not she was a feminist, to which no clear evidence exists—enacted a similar change within medicine.

*Relationality and Community*

Third, Christian anthropology entails relationality and community. The liturgical renewal has raised the awareness of and deepened an appreciation for the communal dimension of human flourishing. Theologians and ecclesial leaders can point to liturgy and the sacraments as critical components in resisting the technologically laden culture of death. Where the essence of technology serves to isolate and conceal, liturgy poses an alternative; it always begins by *gathering* the community.

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Feminist scholarship has also contributed to a fresh appreciation of the necessity of human relationships. Farley describes how feminists “by and large moved to develop a view of human relations characterized by equality and mutuality, in which both autonomy and relationality are respected.” She describes relationality as equiprimordial with autonomy, and feminist scripture scholars argue the early Christian communities were based in equality and reciprocity.

Alasdair MacIntyre notes his indebtedness to feminist scholarship that enabled him to more clearly elucidate the paradox that social relationships are necessary to sustain men and women as independent practical reasoners. He argues that the human transition that moves away from simply accepting what has been taught to making one’s own independent judgments about goods, necessarily entails the participation of “those particular others whose presence or absence, intervention or lack of intervention, are of crucial importance in determining how far the transition is successfully completed.” What MacIntyre and the feminists suggest is that a certain dependence on others actually enables independence. Human independence depends upon the support and gifts from others. We need others to sustain us, to keep us from falling victim to disabling experiences, and when we do, we need others to be our proxy, to advocate for us, and to

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337 Farley, “Feminist Theology and Bioethics,” 92. In her essay, “North American Bioethics: The Feminist Critique,” Farley describes how early feminism championed autonomy as an essential good for women, whose lives have dominated by men. Autonomy gave women claims to rights such as the right to bodily integrity and the rights not to be touched, invaded, or used without free choice or consent. She tempers her critique of the overemphasis on autonomy in Western bioethics with relationality, noting that autonomy is for the sake of relationships and community (Farley, “North American Bioethics, 140–142).


do the things that we cannot do. It is an illusion to think that men and women are and forever will be independent. MacIntyre describes a scale of disability, and throughout periods of life, men and women find themselves, usually unpredictably, at different points on the scale. They need others to help them claim and recognize that they remain the same individuals as before this episode in their life.

**Resurrection of the Body – A Christian View of Death**

To conclude these short observations on a Christian anthropology, I want to draw attention to the distinctively Christian view of death. Above, I noted how the incarnation influences the Christian anthropological characteristics of dignity and embodiment, and I shared Ross’ descriptions of Jesus as a pattern of the Christian life. However, more needs to be said about death—more specifically, the resurrection of the dead.

As examined in the previous chapter, medicine views death as a defeat. Dame Saunders founded St. Christopher’s because she did not accept the growing trend among her physician colleagues that views death as some kind of failure. Rather, she held fast to her belief that death could be beautiful. Her Christian faith profoundly influenced her views and vision. The Christian narrative of the paschal mystery so moved her that the only decorative art adorning the chapel at St. Christopher’s is a triptych of the incarnation, death, and resurrection of Jesus Christ. If Jesus is the model for Christian living, then he is also the model for dying. Thus, the events of his death and resurrection are particularly informative as to how the Christian tradition views human debility and mortality.

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340 Ibid., 73.
341 Ibid., 73–74, and more comprehensively, 70–79.
Death is a human reality, and arguably, it is the most vulnerable experience in human life. Or as some patients with chronic and terminal illnesses describe, they do not fear death so much as the journey toward it. It is understandable that patients and family members grasp for every opportunity to use medical technologies, await with fervent hope for new drug trials, and exhaust every possible medical device before reluctantly succumbing to the pathway dictated by a futility policy. It can be frightening as no one has ever died and come back—except one. And this makes all the difference in the world for Christian believers.

James Alison offers a compelling argument for the resurrection as the epistemological center of the Christian life precisely because it reveals a totally other way of relating to and understanding human existence—namely, the non-definitiveness of death. He describes how Jesus, the crucified, dead and risen one, enacted a radical shift in human consciousness that began with the apostolic group. As Alison’s clever book title suggests—The Joy of Being Wrong—men and women were deluded to assume the definitiveness of death. The resurrection recasts an understanding of God as a free and gratuitously loving God who reaches into the depths of death to bring God’s creatures to a new, transformed life. In the days after the resurrection in their encounters with the Risen one, they gradually began to realize humanity's involvement with death. The historical concreteness of the crucifixion and resurrection bears particular importance for Alison, because it happened to this man Jesus. His own death revealed that “death is not merely a biological reality, but also a sinful reality.” For example, the Passion narratives reveal complicity even among Jesus’ closest followers. Prior to the

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343 Ibid., 117.
resurrection the understanding of death as a part of a sinful reality could not be known by observing human nature. It simply was a given that the dead went down into the hallows, or the “pit.” As Alison explains, death as a sinful reality becomes known because of the interruption of “a revelation of a different sort of Other.” The resurrection of Jesus from the dead revealed that the human being as a creature tied to death, “is itself something capable of forgiveness. Furthermore we can see that the only way we are able to appreciate our true condition as humans-marked-by-death is precisely as it is revealed to us that that condition is unnecessary.” The resurrection demonstrates “that death itself is a matter of indifference to God.” When Jesus was raised, “it became possible to see that God's love for this man was such that that love was unaffected by death, and...love could carry on being reciprocal even through death.” In other words, God has nothing to do with death. Instead, a theological reading of the Easter stories portrays the radical freedom and previously unimagined gratuity of God. Men and women could not have imagined the immensity of God’s love and God’s desire for us to live fully (John 10:10) prior to the resurrection.

Roberto Dell’Oro also emphasizes the resurrection as central not only to a theological anthropology but especially for its intersection with bioethics. He writes, “the Easter event provides a key to interpreting one’s death with all its historical anticipation. If death is not to be the definitive human and moral catastrophe, but rather a passage into a situation of definitive communion with God, then there can be no historical situation

344 cf. Psalm 28:1; 88:4; Clement J. McNaspy argues that the Hebrew Scriptures offer no consistent picture of Sheol in “Sheol in the Old Testament,” Catholic Biblical Quarterly 6, no. 3 (July 1944): 326–33.
345 Alison, The Joy of Being Wrong, 44.
346 Ibid., 119.
347 Ibid., 116.
348 Ibid., 116.
that stands outside of this promise and its power to transform."³⁴⁹ Death, seen through the event of the resurrection, holds a power to fundamentally shape and transform the role of medicine for those with chronic and terminal illnesses. One can begin to experience a newfound freedom, even in the face of death. Seeing one’s own finitude and oncoming death as an event of solidarity with Christ’s own death and glorious resurrection by the life-giving Spirit, can lead to the opening of definitive communion with God. Such an understanding of death and resurrection had a profound impact on Dame Saunders, who was known to say, “I work with the dying, I’m always seeing resurrection.”³⁵⁰ Saunders’ resolute vision of death and resurrection, as a healthcare practitioner, clearly had a significant impact on those for whom she cared. The Christian faith gave her an expanded knowledge. It enabled her to use the best of her training as a nurse, social worker, and physician, while not limiting her to the scope of these disciplines. It freed her from seeing death as the defeat of a medical practice.

Earlier I noted how visitors commented about the lighthearted and joyful sense of her patients and whole environment of St. Christopher’s. Practitioners today can carry a similar sense of an inner conviction, a true peacefulness even amidst the struggle and difficulty of death, and the Christian tradition’s understanding of the paschal mystery can be a powerfully potent way to foster this characteristic. Often, I have observed that physicians know that a particular course of action would be the best clinical option for a patient, and yet they shrink from their clinical judgment. Many reasons account for their timidity. The patient and family may have very strong opinions about the medical

³⁵⁰ Du Boulay, Cicely Saunders, 192.
interventions they want, and there can be very valid reasons for their requests. Physicians in the U.S. fear the potentially devastating effects of a lawsuit and the protracted process that entails, or they worry about their standing with their peers and with hospital administration. Yet increasingly, bioethics conferences, continuing medical education, and the medical literature speak of the need for courage.\textsuperscript{351} Moral courage is needed in the medical practice today. Some have argued that physicians began losing credibility in the post-war years when technology began to overtake medical practice.\textsuperscript{352} This is what made Dame Saunders so interesting. She noticed the awful effects of medicalized dying. She refused to acquiesce to technology’s dominance in medical practice, and her genuine love and concern for her patients sprung up from a Christian view of the human person. Whether the patient agreed or not, Saunders saw them as a composite of body and soul journeying toward the eternal embrace with the Divine One.

These characteristics of a Christian anthropology stand in opposition to a view of human nature imposed by the essence of technology. As seen throughout Catholic social teaching, the pontiffs have asserted the centrality of faith. The Christian faith reveals a particular understanding of human nature, and in so doing, it denies the essence of technology from viewing this nature as utterly manipulable and standing-reserve. The essence of technology would like to reduce men and women to individuals with discrete body parts. Their parts can be extracted, replaced, stored, converted into other materials useful for other individuals to use or consume. To achieve these ideals, the essence of technology makes demands on human nature. Christian faith, however, upholds the truth


that men and women are communal beings. They possess an inviolable dignity that exceeds the sum of their body parts. Moreover, their Christian faith in the resurrection of the dead thwarts the ultimate claim made by medical technologies that seeks to indefinitely extend human life.

There remains a loose end, however. Earlier I noted that John Paul II, followed by Benedict XVI and Francis, began to appeal to sacraments. Somehow, sacraments pertain to changing the culture of death, or more directly, confronting technology and its essence. But how? The argument has yet to be made as to how faith confronts these realities. For the technologically saturated life to be lived virtuously, if not redeemed, it needs a countervailing practice—a practiced and living faith. As one of the theological virtues, faith is not of human origin, but rather it is given by the promptings of the Holy Spirit. The normative manner for growth and nourishment in faith is the Church’s enactment of prayer and song—the practice of the sacramental and liturgical life. \(^{353}\)

But the question remains, what do the sacraments do that is so different from technology? Why would the popes encourage a sacramental practice to temper technology? Is it more than just pious flair?

The work of Albert Borgmann draws together a critique of Heidegger and the assertion that focal things and practices—most especially religious practices and liturgy—act as a counter balance to technology. Focal practices act to buoy the individual and prevent technology from drowning out other modes of revealing.

\(^{353}\) _Sacrosanctum concilium_, §33.
Focal Things and Practices

Albert Borgmann has long grappled with contemporary understandings of technology, and Heidegger’s philosophy influences but does not determine Borgmann’s perspectives. Not unlike Heidegger, Borgmann defines technology as “the characteristic way we today take up with the world.” It is guided by a pattern, one that stretches back over three centuries, and it is so deeply engrained that “the pattern may be difficult or perhaps impossible to see. It reigns as common sense, as the obvious way of doing things which requires no discussion, and more importantly, is not accessible to discussion. It is understood in the sense of being taken for granted.” It is inconspicuous and decisive. Borgmann wants to bring technology to the surface, to evaluate it for what it is, to probe the promises it has made, and to unveil its shortcomings to liberate humankind. Borgmann also offers thought-provoking and convincing suggestions to counterbalance the dominance of technology in the ordinary lives of men and women.

For Borgmann, tempering the totalizing sway of the essence of technology means contending first with its drive to dominate. Informed by Bacon and Heidegger, he explains that the promise of technology is primarily “connected with the aim of liberating humanity from disease, hunger and toil, and of enriching life with learning, art, and

\[355\] Ibid., 35.
It promises a movement of amelioration toward literacy from illiteracy, abundance from starvation, and health from disease.\textsuperscript{357}

This liberation depends on two constitutive elements. First, it needs the standing-reserve as described by Heidegger. Available goods are rendered instantaneous, ubiquitous, safe, and easy. For example, modern pharmaceutics make common pain relievers readily available in developed nations. These convenient medications represent a commodity in this Heideggerian, technological sense because they are enjoyed as an end.

Second, and more importantly, liberation via technology relies upon devices, or what Borgmann calls the device paradigm. Devices are procedures that disburden men and women, making no demands on skill, strength, or attention. For example, an iPod or MP3 player plays music so that I do not have to learn the discipline of practicing an instrument. The best devices conceal themselves completely from the user, and this directly relates to their ability to disburden. For example, a cardiac pacemaker as a medical device fits neatly inside the patient’s chest cavity. It requires no skill, no attention, and best of all, the patient needs to do no regular maintenance. It is carefree and easy—constitutive characteristics of a device. Even more, it, like all devices, is disposable.

Borgmann furthermore observes how devices enable a sense of social disburdenment, and along with consumption, they have displaced human practices. They enable an individual to disengage from the environment and community.\textsuperscript{358} For example,

\footnotesize{\textsuperscript{356} Ibid., 36.\textsuperscript{357} Ibid., 36–38\textsuperscript{358} Borgmann, \textit{Power Failure: Christianity in the Culture of Technology}, (Grand Rapids, MI: Brazos Press, 2003), 31–33.}
a kitchen microwave disburdens the individual from needing to rely upon the cooperation of a cook. One can enjoy a tasty meal without fostering a congenial relationship, at a minimum, with a cook who might otherwise intentionally serve something distasteful. Fast food drive-up windows and carry-out services similarly reduce the interaction between individuals. What is important to notice is how the device paradigm operates at cross-purposes to the communal and relational nature of men and women. Furthermore, commodities like prepared frozen meals eliminate the need to learn kitchen skills to prepare one’s own food. Fostering skills, or what Borgmann calls focal practices, based on focal things, is necessary to circumvent the device paradigm.

Borgmann offers three options for appropriating technology. The first is to plunge headlong into it, or to give oneself over to it in a deterministic fashion as Heidegger did. Second, one can attempt disengagement, pleading ignorance and resentment of technology. This, however, is unlikely and impractical. Instead, Borgmann proposes a middle ground, contending that “technology will be appropriated…not when it is enclosed in boundaries, but when it is related to a center.” He calls this a focal thing, meaning, a focus that “gathers the relations of its context and radiates into its surroundings and informs them. To focus on something or to bring it into focus is to make it central, clear, and articulate.” Focal things tend to be inconspicuous, homely, and dispersed, and his signature image is that of the hearth which once gathered and ritually centered the family in their home.

Moreover, focal things entail an accompanying practice, a skill that must be honed over time, such as playing a musical instrument, mastering a sport, or tending to a

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359 Borgmann, Technology and the Character of Contemporary Life, 168.
360 Ibid., 197.
garden. To illustrate, Borgmann describes the “culture of the table,” where eating a home-cooked meal around the family table differs sharply from the fast food experience. In the home, someone has honed the skills of selecting vegetables and ingredients, knowing flavors that work well together, regulating a charcoal fire or stove-oven heat, and coordinating all with family tastes and preferences. It requires the art of preparing the table, and these practices draw the family together to engage one another. Returning to the example of music, playing an instrument and attending a symphony differ from listening to a Rachmaninoff piano concerto with noise-cancelling headphones connected to a smartphone. The latter elicits little to no discipline or skill. It relies on disposable devices and consumption. It occurs in isolation at the individual’s convenience and commands no attention. The recording can play in the background while one works, plays a videogame on the same smartphone, or exercises.

For Borgmann, the practice of engagement is essential to focally orient human lives toward the physical and social world as opposed to a mere virtual or digital presence.³⁶¹ Focal things and practices restore men and women to natural depths and the wholeness of being human, as they always entail something of the pretechnological world. “Through a practice we are able to accomplish what remains unattainable when aimed at in a series of individual decisions and acts.”³⁶² Technology itself is a type of practice, but it lacks a focal character. In contrast, focal practices confront the facileness of the device paradigm as people encounter one another in the depths of integrity and being, and something is received rather than produced.³⁶³

³⁶² Borgmann, *Technology and the Character of Contemporary Life*, 207.
³⁶³ Ibid., 207–210.
Liturgy as a Focal Practice

For Bormgann, the best focal practices normatively occur in celebrations that are joyful engagements unfolding in a physical presence and entailing the radiance of some concrete thing.\(^{364}\) Borgmann argues for focal practices and celebrations, most especially, religious practices, as the remedy to the device paradigm.\(^{365}\) The celebrations of the Christian liturgical tradition serve as counter practices to the device paradigm. Song, story, and a meal provide the framework for the eucharistic liturgy and correlate to basic focal practices Borgmann investigated throughout his work. Music in a park exemplifies the author’s notion of celebration. Reading to children not only bypasses technological gadgets that can just as easily hold the toddler’s attention, but more importantly, reading to a child fosters bonds of trust and affection. Sharing household meals around a dinner table also engages focal practices that prepared convenience foods and evening television programming threaten. Borgmann explains that for Christians, “it is but a short step from the culture of the word to the Word of God and from the culture of the table to the Breaking of the Bread. This history of salvation that is set out in the Scripture and centered in the Eucharist certainly provides for the scope and coherence that the diaspora of focal things and communal celebrations is lacking.”\(^{366}\) Borgmann’s observation echoes that important theological principle from the Second Vatican Council that the Sunday liturgy is the source and summit of the Christian life of faith. In addition, his work begins to stitch together a rationale for why the ecclesial documents suggested a


\(^{365}\) Ibid., 52–55; 117–128. Celebrations draw people together around some definite thing the way a soccer league or public parade unfolds. Such celebrations contrast with technology and devices, which induce indifference and disengagement that subvert public life. Moreover, focal practices confront the facileness of technology as people encounter one another in the depths of their being, and something is received rather than produced.

\(^{366}\) Ibid., 125–126.
sacramental practice as a foundation for social resistance against the dominance of technology.

The Christian liturgy structured by reading stories and sharing a meal is the foundation of a focal practice that confronts the technological culture. Focal things permeate the ritual: the Book of the Gospels, live musical instruments, water, bread, and wine. The readings must be proclaimed, sung responses or prayers (i.e. hymnody, anthems, or songs) are to come from a live human voice and not recordings, and the gathered assembly is urged to partake in the Eucharist, preferably receiving both the consecrated bread and wine—the Body and Blood of Jesus Christ. The liturgy itself reveals a distinctive way of living and relating to one another and to the wider society. It proclaims and reveals the truth of salvation different than that from technology. It guides the lives of the gathered assembly to live in a distinctive way consistent with the gospel and the paschal mystery. This is what it means to say that the liturgy is formative.

A deeper exploration between liturgy and ethics, or the moral life, will come in the following chapter. The point to be made here is that Catholic theology in the second half of the twentieth century, in various ways asserted that Christian faith could temper the dangers of technology. Prior to the reforms of the Council, the Catholic tradition’s engagement with science and technology consistently asserted the necessity of faith. It seemed as though faith was something that one possessed, like an object or worse yet, another device. The tradition exhorted men and women to have something—namely faith—rather than to do something. The critique of technology from the perspective of

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367 Redemptionis Sacramentum: On Certain Matters to be Observed or to be Avoided Regarding the Most Holy Eucharist, issued by the Congregation for Divine Worship and the Discipline on the Sacraments, 25 March 2004. It states, “So that the fullness of the sign may be made more clearly evident to the faithful in the course of the Eucharistic banquet, lay members of Christ’s faithful, too, are admitted to Communion under both kinds…” §100.
faith prior to John Paul II lacked a fuller account of faith—namely that it is celebrated and that it is a living faith. Men and women can confront technology with faith not merely by claiming to have it, but by practicing it and living it.

This insistence on a focal practice—specifically the practice of faith through the Christian liturgy—is vitally important for those in faith-based health care. It was a practice of faith that inspired Dame Saunders. It was so influential in her dream for the best, most humane, and most loving care that should surround the vulnerably ill and the dying, that she placed the chapel at the center of St. Christopher’s hospice. These same practices of Sunday liturgy and the celebration of the paschal mystery throughout the liturgical year formed and influenced the women religious who founded Catholic healthcare in America. Now more recently, papal documents connect the importance of the liturgy for achieving a balanced, if not a restrained engagement with technology. And these urgings of the pontiffs are not directed to the religious, but to all believers and all people of good will.

I raise this because it remains unknown who or how many in Catholic healthcare practice a faith tradition, any tradition, let alone the Catholic faith. I will say more about Catholic identity in the conclusion of this work. But it is a key concern particularly when considering how to concretize a theological vision of palliative care. I find Borgmann’s argument compelling. If we want to temper the totalizing power of technology, then other mechanisms—other practices—must be put in place. And, practices must be exercised. Without ongoing exercise the strength of the practice itself and its benefits will atrophy and succumb to larger forces. What I am suggesting is that some in Catholic healthcare, at all levels, need to engage in a committed practice of faith. The important
part is the practicing. I am not advocating for ideal, upstanding Catholics, whatever that may look like. I am not suggesting Catholic healthcare needs CEOs, chief medical officers, and directors of critical care units to know bits of Catholic doctrine and parts of the Catechism. Borgmann’s example of practicing and honing the skills to play a musical instrument presents a great image. Catholic healthcare needs palliative care leaders and practitioners to hone a practice of faith—to practice a living faith however imperfect it may be. A practice of faith will strengthen a practice of medical care, transforming it to loving care.\textsuperscript{368} Regardless of how one feels about the institution of the Catholic church, or any other faith tradition for that matter, as flawed as they all are, the practice of the faith—the ongoing commitment to steeping one’s life into the grace-filled richness of paschal mystery will redound not only to the benefit of the individual believer, but also to the benefit of the vulnerably ill and dying.

Theologians Christopher Vogt and Alen Verhey have argued for a contemporary \textit{ars moriendi}—the art of dying well—that would act as a type of shield for individual believers of local faith communities from medicalized dying. True to the late medieval \textit{ars moriendi} tradition, Vogt envisions a life dedicated to fostering the virtues of patience, compassion, and in particular, hope, as necessary dispositions to prepare for a good death.\textsuperscript{369} Similar to Borgmann, Vogt asserts that practices, supported by and integrated into local parish communities, would provide the necessary tools for a contemporary \textit{ars moriendi}. He creatively suggests a parish ministry to the dying that parallels the Rite of Christian Initiation for Adults (RCIA). Just as the RCIA involves formation with the whole parish to initiate and welcome new members in the Catholic church, a parish

\textsuperscript{368} The image of loving care will emerge evermore clearly in the final chapter on love.

ministry to the sick and dying could also draw from the richness of a liturgically-based adult formation that likewise involves the parish community.

I fervently support Vogt’s vision for a strong and sustained parish ministry integrated throughout the community that aims to bring the needs and the experiences of the chronically and terminally ill to the surface of a faith community’s consciousness. However, an obstacle to a contemporary *ars moriendi* is that it places the onus for a good death on the patient. It does not adequately contend with the serious structures of sin and injustice embedded in medicalized dying. Having examined the social justice tradition in this chapter, it is clear that faith, as a necessary balance to technology, must impact not only the individual patient but also healthcare practitioners, physician practices, hospital policies especially for faith-based health care, systemic change, and our national healthcare delivery system.

Critics will say that a humanist can enact palliative care and that a particular faith tradition is unnecessary. That may be true as the Christian tradition’s centuries-long commitment to caring for the vulnerably ill and dying has adequately integrated itself into the ordinary practices of medicine, particularly palliative care. Yet the question remains, what is the center of the humanist’s practice that then provides the boundaries to maintain a proper relationship with technology? What will be the mechanism against which the next generation of technology, the next medical breakthrough, the new slightly adapted medical procedure will be judged? For those of us in Catholic healthcare, those mechanisms include characteristics like the Christian anthropology presented in the chapter. It includes the Gospels, the Catholic social tradition and other ecclesial
documents that engage technology. And, it ought to include one’s own experience of living the paschal mystery through the practice of faith.

Summary

What I have argued in this chapter is that in the twentieth century technology became a primary way of reasoning and understanding the modern world. The essence of technology promised that it would save people from hunger, disease, and even death by disburdening them. This particularly influenced medicine. The theory hits reality in the clinical setting when the emptiness of technology’s promise leads healthcare professionals to frustratingly call for a futility analysis of a patient’s care plan, or at the very least, an ethics consult. The Catholic social tradition both praised and critiqued technology, asserting that a living practice of faith offers an alternative worldview of the human person, one that entails an inestimable worth and dignity, relationality and dependence on a community, and a view of human dying graced by the doctrine of the resurrection of the dead. Recent social teachings and other related papal encyclicals reflect a congruency with Borgmann’s scholarship. He argued that focal practices draw people to one another around a substantial or focal thing that demands their attention and encounters them at the depths of their being. That mirrors the world of the sacraments, where the faithful encounter the living presence of Christ who nourishes their faith and moves them to deeper expressions of love.

This chapter admittedly presents few details on palliative care. A key aspect of palliative care however, is a fundamentally different view of and relationship to medical technology as compared to other medical specialties. Thus, the focus has been to look
behind the advanced medical technologies to scrutinize the underlying logic of technology, or rather, the essence of technology. Second, this chapter drew out criticisms of technology from within the Catholic tradition. The evolution of this critique in the late twentieth century grew to include an appeal to the sacraments. Albert Borgmann’s work served to elucidate how the liturgy and sacraments form men and women in ways different from technology. In the Catholic tradition, the sacraments are celebrations of faith that reveal a form of knowledge. Like a focal practice, the virtue of faith requires presence, attentiveness, and self-involvement, much like a hearth requires skill and human attentiveness unlike its contemporary replacement of a furnace.

Borgmann’s explanation of liturgy as a focal practice helps to understand how Dame Saunders’ faith contributed to her vision for palliative care. Her practice of faith enabled her to see the ultimate futility of an exclusive reliance on medical interventions to relieve human frailty and finitude. This, I believe, was the uniqueness of Dame Saunders. As an alloy to her standard medical practice, she honed the very basic, pretechnological skill of opening up a heartfelt conversation with patients. She elicited from them their hopes, fears, and deepest desires. And she responded with the promise that she and the St. Christopher’s community would help them “to live until they die.”

Faith bounded to love, opens it up to dialogue and engagement with the sciences. As a medical practice palliative care is grounded in the science of medicine, and yet its practitioners are not beholden to the device paradigm. It is able to maintain a distance from the overbearing tendencies of technology, as a way of thinking, because palliative care flowed from a deep conviction of faith from its founder. Saund’s faith prompted her to embrace the sufferings of the sick and dying. Faith gave her a narrative different

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370 Du Boulay, Cicely Saunders, 192.
from one exclusively influenced by Enlightenment thinking that sought to overcome illness or even death. Sustaining an alternate narrative cannot happen without an ongoing practice. Thus, in the next chapter, I examine baptism and Eucharist to explore how these foundational components of the Christian life can form both patients and healthcare professionals in a vision of human decline and dying that is influenced by paschal mystery.
Chapter 3 – Healing, Hope, and the Sacramental-liturgical influence on Palliative Care

*Christ, our hope of glory. (Col 1:27)*

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Part I — The Road to Emmaus

The Gospel of Luke uniquely recounts a key Christian text of how the Risen Lord was made known in the breaking of the bread to two disciples on the way to Emmaus (Luke 24:13–35). It is a rich story of faith, hope, and sacrament.\(^{371}\) It beautifully integrates these two theological virtues, and at its climax is a sacramental encounter with the dead-and-risen Jesus Christ who renews the faith and hope of the two disciples.

The Emmaus story begins on the day of the resurrection, the day that ought to crown the life of faith in Jesus.\(^{372}\) He has been raised from the dead to reveal to his disciples that God’s saving love is faithful and has won victory over their worst fears of oppression, persecution, and even death. Yet for the two disciples, Cleopas and his companion,\(^{373}\) the day is anything but a culmination of faith. Although they apparently witnessed what happened to Jesus in Jerusalem, their departure evidences their diminishing faith.\(^{374}\) They break off from the community of Jesus’ followers who

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accompanied him into Jerusalem. They leave the city, the center of life and activity, and abandon their journey to God.  

The profound sadness of the trauma of a dear friend condemned to death in a public execution wiped away all their hopes and prevented them from recognizing Jesus, the Risen One, who comes to join them in their walking and talking (vv. 15–16). The evangelist, Luke, reveals to us his audience that this is a story of recognition. It traces a movement from not being able to recognize Jesus to a re-cognition of him. The disciples had to re-think and re-consider what it would mean “that he was the one to redeem Israel” (v. 21). In the three days since this hope was dashed by his death and sealed away in the tomb, they had not been able to figure out how any part of these painful events could have anything to do with fulfilling God’s promise of redemption. Their lack of faith manifested itself as blindness; they were blind to the fact that the one with them was Jesus himself, risen from the dead!

After listening to them and hearing of their profound grief, Jesus speaks to the two, and he chides them for being foolish (v. 25), or perhaps, ignorant. The story that unfolds on the way to Emmaus is about truth. There was a truth, a truth about Jesus and about the disciples’ own hopes and desires that they could not see with their own eyes. The disciples recognized the deeper truth only after a Christological interpretation of the scriptures—the Logos himself, the Word made flesh, opening up and proclaiming the

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375 Eugene LaVerdiere makes this very point in his commentary, *Luke* (Wilmington, DE: Michael Glazier, Inc., 1980), 284. Furthermore, one could infer that unlike Jesus who was resolutely clear about the destination of his journey—to Jerusalem—the disciples were headed nowhere in particular. Joseph A. Fitzmyer points out that there is no way of knowing the exact location of Emmaus today. There are at least three possible geographic places that could correspond to Luke’s reference of Emmaus. See, his commentary in the Anchor Bible Series, *The Gospel According to Luke: Introduction, Translation, and Notes* (Garden City, NY: Doubleday, 1985), 28:1561–1562.


377 Ibid., 286.
The re-cognition was made complete with the ritual enactment of the Passover—the breaking of bread and sharing in communion. Together, word and sacrament opened up the possibility for a new insight that allowed them to see their beloved friend Jesus as the Risen One. The events at Emmaus and along the way allowed the two disciples to imagine themselves and their relationship with Jesus anew and afresh. So compelling was this new knowledge and awareness that Cleopas and his companion turn around to go back to Jerusalem to find the eleven and their companions (v. 33), to share with them that the crucified Jesus has been raised from the dead and had been made known to them in the breaking of the bread (v. 35).

The post-resurrection Emmaus story culminates by highlighting the dramatic newness when Luke declares, "he was made known to them in the breaking of the bread" (v. 35). The manner in which they came to this new knowledge that one who is dead is now alive, did not come from mere visual observation. Cleopas and his companion did not intellectually figure out that their travel companion was Jesus. It occurred through word and sacrament. Put differently, seeing does not generate faith.

Knowledge of the facts did little to settle the disciples’ confusion and despondency. The two disciples had to put together their own experience with a proper interpretation of the scriptures and the ritual of blessed and broken bread. The ritual action celebrated and confirmed their faith, or rather, it made available a new knowledge that thereby led them to a grace-filled renewal of hope. With faith and hope they could confidently say to their friends, “the Lord has risen indeed!” (v. 34). In one sense, the story exemplifies what I explored in the

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previous chapter, mainly that faith is a different way of knowing that is received, such as through ritual and a sacramental encounter like the one that occurred on the road to Emmaus.

The story of the disciples on their way to Emmaus reflects similarities to those with chronic illnesses and diseases. Like Cleopas and his companion, they find themselves on a journey traversing the clinical pathways carved out by the knowledge of medical science and its reliance on technology. I examined in the previous chapter how technology imposes itself as a mode of thinking, and thereby it influences the things for which people hope. It becomes second nature for a patient to initially hope that she may live long enough for scientists to find a new device or a new drug regimen that will effectively treat, if not cure her chronic illness. Like the disciples who hoped for a political liberator, patients living in this era of the device paradigm hope for a medical breakthrough. There is nothing wrong with such a hope. It is after all, understandable and nearly unavoidable. The problem is when the medical breakthrough occupies the entirety of the horizon of hope. When the medical miracle does not come, the patient and family can become like the two disciples—dejected, losing faith, and spiraling into hopelessness.

A key to the Emmaus story is the inclusion of the “other.” Cleopas and his companion needed the help of an other to open their hearts and minds to the possibility of something utterly new and previously unimagined. The “other” was Christ Jesus

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381 L.-M. Chauvet notices how the second half of the Emmaus story shifts from a dualistic relation to a triangular relation, “Instead of speaking to each other, in a closed circle, they open themselves to this stranger who has joined them. They break out of their closed conversation to address someone who listens to them. This act of directing a word to a Third who becomes a witness to their consternation lifts a little the heavy stone on their tomb. A thin ray of light penetrates through this tiny crack; their desire awakens anew as they relate to this third person how their hopes have been dashed” (Chauvet, Symbol and Sacrament, 167).
himself, who became known to them in a sacramental ritual. Like the disciples on the way to Emmaus, when patients, their families, and even care providers have the companionship of an other—namely a living faith—accompanying the struggles of illness, then this can help re-form and reimagine a different and new kind of knowing and hope not exclusively reliant on medicine. One way to reimagine the situation of sickness, suffering, and death is through the practice of the Christian sacramental and liturgical life.

This chapter focuses on the sacramental-liturgical life of the church and argues that it can enrich the experience and practice of palliative care for patients and practitioners. Both the Christian faith and palliative care share a view that diverges from predominant views in medicine and modern culture, namely that death is an enemy is meaningless. The sacramental-liturgical life of the church involves powerful focal practices that can support palliative care in resisting the luring perception that medical technology can fix all ills. The church’s ritual activity orientates the believer in a horizon of hope not exclusively marked by a reliance on technology, and it forms the worshipping believer in the pattern of the paschal mystery that serves as an epistemological center furthering the purposes of palliative care.

This chapter opened with an exegetical interpretation of that first post-resurrection encounter along the journey to Emmaus. The story forms the basis for the post-Vatican II systematic sacramental theology of Louis-Marie Chauvet that occupies a central focus of

Robert Karris also identifies hospitality as a symbolic motif that runs throughout Luke’s gospel. In this Emmaus story, welcoming the stranger replaces the “crippling self-concern” the disciples had for themselves and their lives at the onset of the story. See, Karris, “Luke 24:13–35,” 59. J. Bradley Chance interprets the passage as detachment and purgation, particularly as these terms are used and understood by the mystics. He argues that the inability of the disciples to recognize Jesus as the Risen One is tied with their attachment to Israel’s myth of redemption. To see Jesus as the Risen Lord, they needed a different, or an “other” story. See, J. Bradley Chance, “The Journey to Emmaus: Insights on Scripture from Mystical Understandings of Attachment and Detachment,” Perspectives in Religious Studies 38, no. 4 (Winter, 2011): 363–381.
the chapter. He argues against a mechanical view of sacraments, which will help make the case that sacraments substantially differ from the device paradigm. Chauvet posits that the sacramental rituals operate within symbolic exchange. Unlike economic exchange and a technological view of the world, sacraments are gratuitous and gracious, meaning that they are given completely in love as ongoing enactments of God’s covenant to save—or rather to heal—the believer.

Having argued for the sacramental-liturgical life of the church as a counter-practice to that of technology, I next examine how it gives meaning for those with chronic and terminal illnesses. The work of Bruce Morrill will elucidate how the sacraments are rituals of healing.

In the final section of the chapter I explore the healing dimension of two sacraments, baptism and eucharist. The baptismal imagery of dying with Christ and rising to new life with him ritualizes the Christian anthropological view of death and initiates the believer into an ecclesial community committed to the life of the paschal mystery. The weekly, and for some, the daily celebration of the Eucharist nourishes the believer’s life as one centered on the paschal mystery and grounded in the hope that the Spirit of God will raise us all to new and everlasting life, just as it did for the crucified Jesus Christ.
Part II: Sacraments, Liturgy, and Symbolic Exchange in Chauvet’s Sacramental Theology

Sacraments and Liturgy

A sacramental celebration sits at the heart of the Emmaus story. It indicates how sacraments function as celebrations of faith, and they nurture the believers’ faith thereby enabling them to grow in hope. Clarifying the term “sacrament,” however, is of first importance. I provide a moderately substantial explanation on sacraments because they can easily be seen in a similarly mistaken light as medicine. It is tempting to see both medicine and sacraments as quick fixes to our human struggles. In what follows, I describe sacraments as encounters. Far from being a prescription pill, the beauty and effectiveness of encounters depend upon the subjects and their disposition.

For countless generations Catholics learned that a sacrament “is an outward sign instituted by Christ to give grace.”\(^{382}\) This popular definition problematically triggers an image of a mechanical instrument. This is especially likely and true in our contemporary age inundated by technology. In the vastly different era of the Middle Ages, Aquinas retrieved the image of sign from early Church fathers. He defined sacraments as “a sign of a holy thing so far as it makes men [and women] holy.”\(^{383}\) As one reads Aquinas’ treatise on the sacraments, the scholastic Aristotelian categories of matter and form reflect an emphasis, if not a preoccupation with the human categories of the how, when, and what of sacraments.\(^{384}\) The mechanical view of how the sacraments operate, or how

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\(^{382}\) *The Baltimore Catechism*, Q. 136. Public domain.

\(^{383}\) *Summa theologiae*, III, 60, 2. “…quod est signum rei sacrae inquantum est sanctificans homines.”

\(^{384}\) The full engagement of Chauvet’s critique of Thomas’ sacramental treatise can be found in *Symbol and Sacrament*, 7–25.
the bread and wine become the body and blood of Christ, becomes exaggerated in the wake of modernity and in the technological world. The view of sacrament as sign reflects a connotation of automation, as if sacraments dispense grace to the faithful like a vending machine. The undesired result theologically, is the perception that grace is a product, an object, or an instrument that provides a remedy.\(^{385}\) This tends toward an individualistic interpretation whereby the believer is a passive recipient of grace who gets a sacrament. Such a view lacks an understanding of church as a community of faith, and it inadequately communicates a sense of responsibility of those baptized into the life of Christ Jesus to assume and to carry on the church’s mission. More regrettably, many faithful see the sacraments as something performed primarily by the priest that will then effect something interior in their soul.\(^{386}\)

**Sacrament as Encounter**

Concerned by an overly simplistic portrayal of sacraments, Edward Schillebeeckx revitalized sacramental theology in the mid-twentieth century and subsequently

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\(^{386}\) So prevalent was the image of sacrament as sign or instrument by the mid-twentieth, with all the theologically problematic connotations described, that Chauvet found not even one reference to faith in a 1947 catechism, and no appearance of the word church, other than to indicate the institution into which one is incorporated at baptism (Chauvet, *The Sacraments*, xv).
influenced the documents of the Second Vatican Council. He presented sacraments as entailing grace, and every experience of grace is an encounter with God. Different from the logic of a sign, an encounter entails the active interplay between the parties. As the source of divine love, God offers grace, which is then realized concretely and historically as a supernatural divine gift within creation. The encounter of grace reaches its fullest expression in the person of Jesus. Schillebeeckx draws from the Chalcedonian christological formulation of the “one person in two natures” as the grounding for his argument that “the man Jesus, as the personal visible realization of the divine grace of redemption, is the sacrament, the primordial sacrament.” Jesus, as human and divine, witnesses the reality that the sacramental encounter involves a movement from above and from below. Jesus is the fullness of grace. His human life reveals acts of redemption, reflecting God’s saving love from above. Seen from below, his actions are characterized as acts of worship reflecting Jesus’ love of God.

This two-fold movement continues in the church, which itself is the sacrament of the Risen Christ. Jesus created a community of a redeemed people of God, for whom Jesus himself is the head. The Acts of the Apostles describes the feast of Pentecost as commemorating the ongoing mystery of Christ Jesus’ redeeming loving “in and through the Holy Spirit who now realizes and perfects in us that which was completed in

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387 Sacraments entail the participation and the disposition of the recipient. See, Karl Rahner, “How to Receive a Sacrament and Mean It,” in The Sacraments: Readings in Contemporary Sacramental Theology, ed. Michael J. Taylor (Staten Island, NY: Alba House, 1981), 71–80. One can also see how this logic influenced the Council to call for all the faithful to engage in “full, conscious, and active participation in liturgical celebrations” (Sacrosanctum concilium, §14).


389 Ibid., 18.

390 Ibid., 47.
Christ. Thus, Schillebeeckx declares, “the earthly Church is the visible realization of this saving reality in history. The Church is a visible communion in grace.” It comprises both members and hierarchy, just as the sacramental Christ is head and body. The church, is “a community of salvation and worship,” perpetuating the ongoing rhythms of the Divine encounter from above and from below. The seven sacraments then, flow from the church. They are personal encounters with the risen Christ. Put differently, “a sacrament is the saving action of Christ in the visible form of an ecclesial action… To receive the sacraments of the Church in faith is therefore the same thing as to encounter Christ himself.” It is a ritual action of the church that makes Christ himself present to the worshipping body offering divine healing and salvation.

A word also needs to be said about liturgy, primarily because it is the context for celebrating the seven sacraments. The origins of “liturgy” derive from the Greek *leitour gia*, meaning “the work of the people.” It connoted a duty to public service offered for communal benefit. Thus, it came to be used for cultic service rendered to God.

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391 Ibid., 24. Emphasis original in the author’s text.
392 Ibid., 47. The English translation writes church with the capitalized ‘C’ which I have maintained in the direct quote. I, however, have chosen to refer to the church with the small ‘c’, in part to reflect an appreciation for an ecumenical dimension in contemporary Christianity. Schillebeeckx revealed his own openness to a sacramental dimension in “The Separated Christian Churches,” (Ibid., 184–196). Moreover, it can be common for Roman Catholics and other Christians to associate the “Church,” particularly when printed as such, with the members of the hierarchy. By writing “church” in this manner, I intend to reference the entire people of God and all of the baptized.
393 Ibid., 48-49.
394 Ibid., 51.
395 Ibid., 54.
396 Chapter One offered a definition of liturgy from Aidan Kavanagh: “It is simply the church living its ‘bread and butter’ life of faith under grace, a life in which God in Christ is encountered regularly and dependably as in no other way for the life of the world” (Kavanagh, *On Liturgical Theology*, 8; See also 74–76). Like sacraments, liturgy presumes faith. Moreover, Kavanagh describes liturgy as sacramental as it is an ongoing and dependable encounter with Christ.
Liturgy represents a larger theological category than the sacraments as it entails rituals beyond the seven, such as the Divine Office, blessings, the profession of vows, and wakes, among other celebrations. It has been said that liturgy is sacramental and sacraments are liturgical. This implies that the liturgy entails an encounter with Christ, and that sacraments participate in a communal offering of thanks to God. Reclaiming the word “liturgy” in place of locutions such as “going to mass” or “getting a sacrament,” “revitalizes a sense of the church’s sacramental rites as the symbolic and, in the power of the Holy Spirit, very real participation of all the faithful in the divine-human mystery of creation and redemption.”\textsuperscript{398}

In sum, Schillebeeckx effected a shift in sacramental and ecclesial understanding. He initiated a fresh articulation of sacraments as encounters with the living Christ Jesus who offers grace, and in return, the Christian faithful offer worship and prayers of thanksgiving. The church is not a mere institution or guardian of truth. It is a sacrament, the visible living presence of Christ, offering God’s communion and saving grace.\textsuperscript{399}

Schillebeeckx’s theology serves to arrest a creeping temptation to view grace in a technological framework. Rather than producing, sacraments are engaging. The sacramental theology of Schillebeeckx serves as the foundation upon which Chauvet builds his systematic sacramental theology. Additionally, Luke’s post-resurrection narrative of the two disciples who moved from grieving despair to proclaiming Jesus’ resurrection, exemplify how sacraments can mitigate an encounter with divine healing.

\textsuperscript{398} Bruce Morrill, \textit{Divine Worship and Human Healing}, 7. Emphasis original in the author’s text. Morrill clarifies the term “mystery” by writing, “At the origins of Christianity, mystery was not about esoteric cults or secret rituals but rather the revelation that in the person and mission of the Jewish eschatological prophet Jesus of Nazareth, crucified by sin but raised to life by the Spirit, God’s purpose for creation has been fulfilled” (Ibid., 7). In this theological usage, “mystery” should not be seen as something that baffles or cannot be understood. In a Christian sense, “mystery,” dawns upon the light of intelligibility because it pertains to Christ Jesus, yet it can never be exhausted of meaning. It is infinitely knowable.

\textsuperscript{399} \textit{Lumen Gentium}, “The Dogmatic Constitution on the Church,” §1.
Chauvet’s theology will advance my argument that the sacramental-liturgical life of the church can powerfully support palliative care as a medical practice that prudently scrutinizes the usefulness of modern medical technologies against the desires and personal values of the patient. Moreover, the ecclesial dimension of this sacramental theology will support the aim of palliative care to involve the patient’s bonds of love to family and community.

**A Fresh Sacramental Theology – Louis-Marie Chauvet**

Chauvet constructs a contemporary theology of sacraments influenced by the theology of the Second Vatican Council, and hence it bears the fingerprints of Schillebeeckx. Yet different from his twentieth-century theological peers, Chauvet based his systematic sacramental theology in symbolic exchange and the philosophy of gift. First, I will specify a meaning for the theologically precarious word “symbol.” Next I will explain the important features of Chauvet’s symbolic exchange, which I believe is best described as gift-exchange. The association of gift-exchange with the formation of

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400 I describe Chauvet’s theological contribution as a systematic sacramental theology because of its comprehensive nature. He does not singularly focus on the sacraments. His work incorporates scripture, sacrament, and ethics, along with ecclesiology, christology, and pneumatology.

Christian identity will offer a sharp contrast to economic exchange and the technological view of the world. In other words, viewing sacraments as gift-exchange will delineate how the sacramental life of the church engages the lives of men and women differently from the essence of technology. Lastly, understanding the sacramental-liturgical life of the church as gratuitous and gracious gifts will enable a connection to palliative care, as both stand as alternatives to the technological way of life.

Chauvet offers a conceptual model of sacraments grounded in the vision of the Second Vatican Council. He argues that his model overcomes the multiple problems of identifying sacraments as signs. The model is depicted as an inter-related triangular form with God at the top and sacraments and humankind on the left and right respectively. Each variable has a mutual relationship and purpose to the other two. When moving clockwise through the model, (God→humankind→sacraments), God acts freely and perfectly to share God’s life-giving love with men and women. Then, the sacraments express “the summit of the life sanctified by God’s grace and the revelatory expression (the sign) of this sanctification.”

In this sense, sacraments are understood as “acts of gratitude toward God,” and concrete manifestations of human worship. A counterclockwise movement through Chauvet’s model, (God→Sacraments→humankind) is just as important. Here, God provides the sacraments through Christ and in the Spirit to sanctify men and women. Their very lives then, become an offering to God. Both flow patterns are operative in Chauvet’s sacramental theology, and both are necessary for a full appreciation of the import of the sacramental-liturgical life of the church. This framework overcomes the problems that arise when perceiving sacraments as signs, or

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401 Chauvet, The Sacraments, xxiv.
402 Ibid., xxiv.
403 Ibid., xxiv-xxv.
worse, as unidirectional and consumable packets of divinely offered grace. Chauvet’s starting point positions sacraments as the summit of the Christian life, and simultaneously, the source for virtuous Christian living.

**Defining Terms: Symbol and Liturgy**

A second foundational concept is necessary to best understand Chauvet’s sacramental theology, and that entails his preference to describe sacraments primarily as symbols rather than merely signs. If not understood properly this twentieth-century shift away from the patristic and medieval concept of sign can be problematic. A common interpretation that remarks, “Oh, that is just a symbol,” or “It was merely symbolic,” poses problems for a sacramental theology that seeks to communicate God’s real presence through the seven sacramental rituals. Chauvet posits a precise understanding of symbol that is free of individualistic interpretation. Reducing them to interesting

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404 Chauvet labels the descending view of sacraments as the “objective model.” God initiates salvation for men and women via the sacraments: God → Sacraments → Humans. Many Catholics grew up with and hold this view of sacraments. They are things that God has given them to grow in faith, and they serve as a means of salvation. Chauvet contends that this perspective has its roots in Aquinas’ treatise on the sacraments. The French theologian acknowledges, however, that Thomas did not altogether ignore the reverse flow, whereby men and women offer the sacraments as “spiritual offerings” (Rom 12:1; Heb 13:15–16; Pet 2:4-10) of praise to God: God ← Sacraments ← Humans. Given how prevalent the technological view of the world is today, it is difficult to imagine that any more than a few contemporary Catholics consciously view sacraments in this alternative manner.

The French theologian posits an alternative model, the subjectivist model, less prevalent in Roman Catholicism and less pertinent to my argument regarding a sacramental influence on palliative care. Here, sacraments are perceived as celebratory recognitions of what God has already accomplished in the lives of the believers. It emphasizes God directly relating to men and women, who then employ sacraments as festive acknowledgement of God’s activity in their lives. This view enjoys favor among Christians who emphasize acts of social justice over Christian ritual, or among some Protestant traditions, particularly those that emphasize the sovereign freedom of God (Chauvet, *The Sacraments*, xiii–xvi).


stimuli for one’s own vast imagination and subjective experience strips the sacraments of their deeper essence and theological impact.

The etymology of the word is his point of departure. The Greek verb \textit{symballein} signifies, \textquotedblleft to throw together.	extquotedblright\textsuperscript{407} They conjoin and forge two or more things in a harmonious union, especially things that would ordinarily tend apart. When two things are symbolized or linked together, they possess new meaning.\textsuperscript{408} In their sacramental sense symbols outwardly express what they really signify. A symbol bodily manifests, real-izes, and even speaks its own presence. It belongs intrinsically to what is expressed. When a Eucharistic minister offers the cup of consecrated wine to a communicant with the words, \textquotedblleft the Blood of Christ,	extquotedblright those words express a reality pertaining to the minister herself, the consecrated wine itself, and the communicant himself. Symbols fundamentally differ from signs. Conversely, a sign points to and relates to something other than itself. A traffic sign with the word \textquotedblleft STOP,	extquotedblright does not actually realize or participate in my action of depressing the break pedal in my car. The traffic sign points to the action that should be taken. In so doing, it indicates something beyond the actual metal sign itself.

\begin{footnotesize}
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\item \textsuperscript{407} Chauvet, \textit{Symbol and Sacrament}, 112–124.
\item \textsuperscript{408} The word connotes a sense of bringing things together, to hold in common, or to exchange. Symbols are not limited to tangible things, and are frequently used in an intangible action like that of conversation. The Greek phrase \textit{symballein logos?} is to exchange words, and can refer to meeting or conversing. They can be mannerisms or passwords that unite people and forge an identity that goes beyond the two individuals. Chauvet borrows from Heidegger’s philosophical writings. The French theologian makes an analogy that Heidegger’s understanding that language is the womb of being human is akin to the Christian sacraments being the womb for being Christian. Heidegger posits that a primordial understanding of the Greek words \textit{logos} and \textit{legein} and \textit{lessen} in his native German, mean to gather, to collect, and to read. Other variations of the word, depending upon context, include the following: to gather, the cream of the crop, to read a book, to put one thing with another, to bring together, to gather, to collect, collection. Heidegger points to similar usages in Homer’s \textit{Odyssey} (XXIV, 106) and Aristotle’s \textit{Physics}, (Θ I, 252a 13). Heidegger’s \textit{An Introduction to Metaphysics}, trans. Ralph Manheim, (Garden City, NY: Doubleday, 1959), 105.
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Chauvet uses this understanding of symbol and applies it to the sacraments. The church’s sacraments, theologically understood as symbols, form Christian identity because they unite the very human lives of the worshipping body with the Triune God. They not only remember but they really bring about the saving actions of Christ in the Spirit. This occurs through the process that Chauvet describes as symbolic exchange.

**Symbolic Exchange and Gift**

Arguably one of the richest aspects of Chauvet’s sacramental theology is his interpretation of how the symbolic exchange between scripture, sacraments, and ethics, forms Christian identity. These three building blocks of Christian identity correlate to a fundamental anthropological structure of knowledge, gratitude, and ethics. This exchange, however is no ordinary exchange. It is an exchange based on gift theory, and thus, I believe it is best understood as *gift*-exchange.

Chauvet juxtaposes the gift-exchange of Christian sacraments against the backdrop of the quotidian market exchange. The latter takes place through the use of money or bartering. It thrives on a mutually recognized quantitative system. One person supplies a product and the receiver in the transaction offers to the seller some agreed

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410 I acknowledge the economic overtones to Chauvet’s choice of terms, most notably the word “exchange.” Some thinkers, such as Oliver O’Donovan, contest that using the word “exchange,” especially in the context of symbolic (i.e., sacramental) exchange undermines the intended contrast to economic exchange. O’Donovan argues that “exchange” is an inappropriate term for theology as it is foreign to the Christian understanding of community. See Oliver O’Donovan and Joan Lockwood O’Donovan, *Bonds of Imperfection: Christian Politics, Past and Present* (Grand Rapids, MI: Eerdmans Publications, 2004). Chauvet, however, directly delineates the differences between market exchange and symbolic exchange. Moreover, the ecclesiology operative throughout his works clearly reveals his understanding of the centrality of the Christian community. Lastly, Chauvet orients his sacramental theology within a “Trinitarian Christology,” further evidencing his commitment to a communal understanding of Christian theology and the sacraments. This is notably different from sacramental theologies that overemphasize, if not exclusively identify the sacraments with Christ Jesus. The Trinitarian perspective implies a community and mitigates against O’Donovan’s claims that exchange occurs between two equal agents.
amount of money or other equal exchange of goods or services in return. This is not unlike the expectations that we have when we turn to the medical profession in our times of sickness. We have an ailment and we anticipate, if not expect, that some therapy will counteract the pathology, be it a drug, a surgical intervention, or some type of helping device. A patient presents to the emergency department with sharp pains in the lower right abdomen, and the surgeon performs an appendectomy, relieving the pain. Yet increasingly, a growing number of men and women living with chronic disease and multiple comorbidities do not so clearly benefit from any one intervention or remedy. Palliative care is especially interested in patient conditions for which there are no clear, obvious cures. The following section aims to argue how the logic of gift-exchange can support the work of palliative care teams.

Gift-exchange follows a logic different from market exchange. It is based on an understanding of gift that mediates between two entities. For something to be a gift, three things must happen. First, a gift is given. Second, the receiver needs to demonstrate that the gift has been received as gift, lest it be mistaken as something that has been seized or stolen. To ensure proper reception, a third step follows that involves a return-gift. This may seem odd or even disingenuous to suggest the necessity of a return-gift for the active fulfillment of gift-exchange. This return-gift, however, need not be a physical gift. It can be as simple as an acknowledgement of gratitude, verbal or non-verbal, such as a smile offered back by one who has just received a compliment. The

411 John Milbank questions whether it is even possible for a true gift to be given. He avers that a gift is possible, not as “pure” gift,” but as “purified gift-exchange.” He adds the qualifier “exchange” because a non-identical return-gift is necessary, usually given to an other and usually after a delay. He concludes arguing for “agape as the consummation of gift-exchange,” a concept I treat in the final chapter. John Milbank, “Can a Gift be Given? Prolegomena to a Future Trinitarian Metaphysic,” Modern Theology 11 no. 1, Jan. 1995, 119–161. Milbank is responding to Jacques Derrida’s claim that a gift cannot be given. See, Jacques Derrida, The Gift of Death, trans. David Wills (Chicago: University of Chicago Press, 1995).
point is that every gift, at a very minimum, creates an obligation or a moment of gratitude. When gratitude is not extended, it appears the gift has been seized. The failure to offer a return-gift disrupts the flow of gift-exchange and identifies one of the liabilities of gift theory. It is unequal, unenforceable, potentially manipulative, and in the eyes of a liberal democratic economy, unjust. The point I am making here is to establish the basic contours gift-exchange operative in the sacraments. Kathryn Tanner eschews the language of “obligation,” arguing that it does not serve well the particularities of the divine economy. Instead, she prefers the language of “communion” for its quality of disinterested grace. I am unconvinced by Tanner’s argument. I find Chauvet’s argument compelling as he overcomes the economic, instrumental, and technological overtones by insisting on the qualities of sacramental gratuitousness and graciousness.

**Gratuitousness and Graciousness**

By definition gifts are gratuitous, meaning they come without merit. As gift offered by Christ himself through the Spirit, sacraments are examples of gratuitousness par excellence. God gives for no reason except to express the love that God is. It is God’s nature to give, and all giving done by God is gratis, extra, over and above, for God
has no need to give." Chauvet describes, it is a “free gift, which can in no way be
demanded and which we can in no way justify.”

The gratuitousness of grace is twinned with graciousness. The former referred to
the unmerited quality of grace, while graciousness refers to the fact that the gift is offered
*without calculation*. It is beyond utility, transcending the limits of measurement, and
characterized by super-abundance. “Theologically, grace requires not only this initial
gratuitousness on which everything else depends but also the *graciousness of the whole*
circuit, and especially of the return-gift. This graciousness qualifies the return-gift as
beyond-price, without calculation—in short, as a response of love.” Taken together,
the gratuitousness and graciousness essential for gift-exchange reflect the reality that
sacraments and their grace cannot be seen as objects, finished products, or items of value.

For the contemporary believer participating in the sacramental-liturgical life of
the church, the grace that is operative stands as a counter-witness to the technological
way of life. Recall that for Heidegger the essence of technology relies upon the fact that
it is “standing reserve”; it is always and everywhere available for use. But grace, like
manna, which the Israelites found could not be containerized and kept for purposes
beyond the Lord’s original intent (Gen 16:4–35), comes completely from outside the
realm of mere human powers and surpasses usefulness. It is gracious gift.

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417 Ibid., 108–9.
418 A most beautiful and explicit biblical image of grace is manna. The manna in the desert defies
the logic of value and empirical verifiability. It is everywhere, and yet it seems to come from nowhere. It
fills the people in the present moment, but it cannot be left to gather or access later. Those who left some
until morning found it crawling with worms and emitting a stench (v. 20). It cannot be quantified as “those
who gathered much had nothing left over, and those who gathered little had no shortage” (v. 18). Its very
etymology is a question: *Man hu?* Meaning “What is this?” (v. 15). It seems to be something, but at a
closer look it is no-thing. It is something as fine as the frost on the ground and melts in the sun (vv. 14, 21).
What I hope is becoming apparent is how gift-exchange confronts the mechanical and instrumental worldview, including that of sacraments. A non-mechanical or non-instrumental view of sacraments reinforces the point made in the previous chapter that the liturgy is a focal practice counterbalancing a technological mode of reasoning. Sacraments are not "fixes" for a broken human heart in just the same way Bishop argues that medicine ultimately is not about, or should not be primarily about fixing broken bodily parts and systems. Symbolic gift-exchange provides a framework from which we can confront the dominant medical mindset that the science of medicine ought to fix human bodies in the way a mechanic fixes a car. By casting sacraments as constitutive elements of gift-exchange, Chauvet confronts the consumerist mindset that views both ritual and healthcare as places where men and women expect to “get” something.

In the sacramental-liturgical encounter, men and women become something. We are formed into the living body of Christ—the one who has died and has been raised to life again! Allowing one’s life to be formed by the paschal mystery and more deeply cultivating this Christian identity may help the individual discern the benefit and virtue of technology or an exact proposed course of medical treatment, as well as the shortcomings, unrealistic hopes, and inadequacies of a treatment. What I want to be clear is that a life patterned and formed by the gift-exchange of the Christian sacraments gives the worshipper a freedom to live more fully and authentically like Christ. The implication for individual men and women, as well as for medicine, is that vulnerability, illness, and mortality can be approached with a freedom that reflects Christ Jesus’ trusting acceptance.

It is a question, a non-thing, and a non-value. Chauvet wonders, “How can we make sense of this pure sign which begins with a question, other than by choosing the path of symbol, the path of non-calculation and non-utility?” (Chauvet, *Symbol and Sacrament*, 45).

Chauvet discovers and explains how symbolic exchange runs through the entirety of Eucharistic Prayer II (Ibid., 268–280).
of these human difficulties. This is not to say that Jesus easily inhabited this freedom. The agony in the garden witnesses to the profound struggle. At the same time, the gospels as well as the Pauline literature describe Jesus handing himself over (Mt 26:52-54; Lk 22:49–53; John 18:8, 11; Phil 2:6–8). Jesus accepted this bitter human inevitability but paired with a fervent abiding trust in God’s sustaining love.

**Emmaus Revisited – The Pattern of Gift-Exchange**

I opened this chapter by recounting the Emmaus story because it is Luke’s first account of the disciples encountering Jesus resurrected from the dead. Chauvet uses this story as an example of symbolic exchange that reveals the unique pattern of Christian identity comprising of scriptures, sacrament, and ethics. \(^{420}\) The scriptures are God’s gift. \(^{421}\) They recount salvation history, and they tell of God’s presence in past activities of human living. In the ritual unfolding of the sacraments the gift that the scriptures are, namely God’s offering of salvation, is given to the worshipping body. The scriptures recount God’s living and saving presence in the past, while the sacraments themselves make real God’s living and saving presence in the present. \(^{422}\) They embody in the very present moment the saving actions of God through Christ, the primordial sacrament, and in the Spirit. The sacramental-liturgical action is the way in which the worshipping body

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\(^{421}\) Chauvet, *The Sacraments*, 29. Chauvet identifies scripture as anything that pertains to “the knowledge of God’s mystery revealed in Jesus Christ” (Ibid.). He includes the Bible, theology itself, and catechesis as elements under a broad interpretation of “scripture.” Regarding theology, Chauvet sees that it “is at bottom nothing else than the orderly and critical organized elucidation of the difficulties present in our foundational texts. Catechesis belongs also, at least in large part, to this pole of Christian identity which immediately depends on biblical revelation” (Ibid.).

\(^{422}\) One can consider a word play and synonymous association between a gift and a present. John Milbank notes that the present moment can only be received as gift (Milbank, “Can a Gift be Given?” 121).
receives the living presence of the dead-and-risen Christ Jesus. The Emmaus story shows the movements of this very dynamic.

Chauvet relates the three constitutive elements of scripture, sacraments and ethics as gift, reception of gift, and return gift. The story opens with the two disciples in state of non-faith that transitions into faith and hope. Faith begins not by adherence to a set of rules or dogma, but rather by a renunciation, absence, or possibly death. Cleopas and his friend express their loss of hope that Jesus would have been “the one to redeem Israel” (v. 21). Next, they received something meaningful about the crucified and risen Jesus when he interprets the Scriptures for them. The word alone was not enough; a ritual action that made the Risen Lord’s presence present to them in the breaking of the bread was essential. At this climax of re-cognition, Jesus vanished. Now that the disciples

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423 For Chauvet, all three descriptors are representative of Christ. They also represent the past, the present and the future. The scriptures are the same as gift, and they signify Christ's presence in the past. Sacraments are the reception of the gift by the worshipping body and reflect Christ's presence in the present. In this way, we can understand the doctrine of the Eucharistic real presence. To distinguish a gift from something that is taken, claimed, or stolen, there must be a return-gift, or something that acknowledges reception of the gift. The Christian life witnesses the reception of the gift by the distinctiveness of Christian living, or what Chauvet calls ethics. He describes ethics as the future presence of Christ for it is the way we go out from the sacramental celebration to make Christ's presence known in the world by our actions. It is future orientated. For a helpful diagram see, Chauvet, Symbol and Sacrament, 278.

424 This is central to Chauvet’s theology and explanation of symbolic exchange. He insists that there must be “a renunciation of a direct line, one could say a gnostic line to Jesus Christ. It is impossible to truly recognize the Lord Jesus as living without giving up this illusory quest—an ambivalent psychic impulse...which irresistibly leads us to desire to see, touch, find, that is, finally to prove, Jesus. For, exactly like the women or the disciples running to the tomb, what could we see, what are we expecting to see and to know, if not the corpse of Jesus? (Chauvet, Symbol and Sacrament, 172–173). Chauvet’s sacramental theology rests on notion that what is real is always mediated, it is never experienced directly. The Church, as the Sacrament of Jesus Christ, mediates the presence of Christ through the sacraments in the same way that Emile Benveniste, Claude Lévi-Strauss, and Heidegger, among others, see language as the womb of being that mediates all reality (Chauvet, The Sacraments, 6–17). To accept mediation is to accept a loss, it is the loss of a direct, unmediated experience. Chauvet notes that the disciples had to believe the message of the angel that the tomb was empty. The desire to see and find the dead, buried body of Jesus continues to manifest itself today in a “closed system of religious knowledge,” sacramental “magic,” and “moralism” (Chauvet, Symbol and Sacrament, 173–174). In other words, all three represent the desire for certainty. Christ rose from the dead and ascended into heaven. “Christ has departed; we must agree to this loss if we want to be able to find him. To agree to this loss...is equivalent to consenting to its symbol: the Church” (Ibid., 177).

425 Scripture scholars confirm the reading of that passage offered herein, such as that by Raymond E. Brown who writes, “They recognized him only when he broke bread;” in An Introduction to the New
had reinterpreted the scriptures through the hermeneutic of the resurrection and encountered Christ's presence in the sacramental ritual, they can respond to this new experience of absence differently than their reaction to the empty tomb.

Cleopas and his companion begin to grow into their newly given Christian identity. Their encounter with the risen living body of Christ in word and sacrament enwrapped them in the paschal mystery. The vacuum left by Jesus' mysterious disappearance (v. 31) a moment of consideration in which they are empowered to go back to Jerusalem. Chauvet describes this moment of opportunity to continue participating in gift-exchange as the ethical dimension of faith. The obligation of this return-gift is essential, for “faith can exist only if it expresses itself in a life of witness.... [T]here is no possible reception of the gift of the good news of the resurrection without the return-gift of Christian witness.” In other words, ethics flows from sacraments, and without the latter, the former suffers severe impoverishment.

This is the critical point in the story for it is the moment of the possible return-gift. It is nonsensical, however, to give something back to God, for God has no need for

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Testament, (New York: Doubleday, 1997) 261. LaVerdiere suggests that the disciples represent the Lucan communities who suffered as well from their inability to recognize the Lord in the midst of their sufferings and persecutions; LaVerdiere, Luke, 284.

426 See Chauvet, Symbol and Sacrament, 164-166. The same opportunity is presented to the Christian faithful at the end of every eucharistic celebration, as the dismissal formulae eloquently exhorts them, “Go now to proclaim the Gospel with your lives.”

427 Ibid., 164.

428 The implication is that a properly positioned Christian ethic and moral theology is incomplete without a grounding in God’s ongoing activity in the sacraments. Timothy M. Brunk argues that although Chauvet makes the clearest and most convincing argument for the connection between sacraments and ethics, Chauvet’s theology followed a similar line of intellectual thought created by other prominent twentieth-century theologians such as Karl Rahner, Edward Schillebeeckx, and Bernard Häring, and to a lesser degree the work of liberation theologians like Jan Luis Segundo. Prior to the Second Vatican Council, Virgil Michel pioneered the liturgical movement in American and connected the liturgy to social justice. The theological connection between worship and ethics is not unique to Roman Catholics. Brunk points to the works of Methodist theologian Don Saliers, and to that I would add Stanley Hauerwas. See Brunk’s work, Liturgy and Life: The Unity of Sacrament and Ethics in the Theology of Louis-Marie Chauvet (New York: Peter Lang, 2007), 9–56.
human praise or gifts. This is why return-gifts differ from the original gift and given to
an other, not the giver. Chauvet proposes that a return-gift is ethics, which refers to the
way Christian believers live their lives, enter into relationships, and reflect the biblical
world. As a return-gift, ethics may entail something such as faith, love, the softening and
conversion of hardened hearts, evangelization, charity, or living the gospel.\footnote{Chauvet, The Sacraments, 124; and Chauvet, Symbol and Sacrament, 268–280.} The
sacraments are the impetus for transforming lives and fostering virtue. Recall that Dame
Saunders insisted that the eucharistic chapel stand at the center of St. Christopher’s
hospice, so that it would inform every aspect of the loving care offered to the residents. I
will return to the connections with the Eucharist at the end of this chapter, but first, I
want to further explore how the sacramental rituals function as a focal practice that
counterbalances the technological way of life.

**Liturgy and Technology**

Similar to Christopher Vogt’s call to foster a contemporary *ars moriendi*
structured around the liturgical cycle, Richard Gaillardetz argues more broadly that a
sacramental worldview “can help us cultivate the skills of discernment necessary to
negotiate successfully the demands that this technological age places on us.”\footnote{Richard R. Gaillardetz, Transforming Our Days: Finding God Amid the Noise of Modern Life (Ligouri, MO: Ligouri Publications), 25. See also, 108–109. Gaillardetz was influenced by his own reading of Borgmann, including the philosopher’s argument for a “transformed dailiness,” which he sees began with the eucharist. See Albert Borgmann, “Christianity and the Cultural Center of Gravity,” Listening, 18 (1983): 93–102, at 99–100. Also,} The
sacramental elements are taken from creation itself as graced gifts from God. Liturgies
do not extract the Christian faithful from the world. Rather, they aid the faithful to live
and embrace the world in a way that God intended the world to be lived—in grace-filled
communion with creation, with one another, and with God. Technology functions as a fix to something that goes awry in the normal course of living in this broken and imperfect world. Technology presents an escape hatch from reality, offering instead, virtual realities. By contrast, the liturgy takes seriously the difficulties and challenges of human life.

Gaillardetz argues that sacraments “break open our daily life and offer us a new vision of its graced character.”\(^{431}\) The sacraments are like a black light that illumines the residue in life that obstructs the ongoing rhythm of the paschal mystery of life, death, and new life.\(^{432}\) The liturgy becomes essential because technology has so radically changed us and altered creation, denigrating it into standing-reserve. Gaillardetz writes:

> When technology devalues human engagement, commodifies human goods, eliminates all forms of human friction, and circumvents all experiences of human limitation, our capacity to enter into this liturgy of the world is diminished. This diminishment heightens our need for the liturgy of the church as the ‘sacred place,’ properly understood in which we discover the ‘holy ground’ that is our daily life.\(^{433}\)

For Gaillardetz, the Christian community gathered in liturgy and the rituals that unfold therein, offers a vital framework within which the worshipping believer reflects upon her life and the many forces that challenge her, beg for her attention, and clamor for her commitments. The daily, weekly, seasonal, and yearly flow of the liturgy that ritualizes and enacts the paschal mystery, opens up the believer’s life to the endless offering of divine grace in the world. Like Gaillardetz, I believe that an ongoing discernment and critical reflection on what is good, just, and graced in the world and in our lives will reap great benefits. Engaging a sacramental-liturgical practice holds the potential to impact

\(^{431}\) Gaillardetz, 76.
\(^{432}\) Gaillardetz, 76.
\(^{433}\) Gaillardetz, 87.
the believer when a medical crisis arises. It can give direction, meaning, and stability when one’s circumstances forces him to renegotiate and transition to a new daily experience of living with a chronic condition. In addition, Gaillardetz’s insights apply to those involved in healthcare. The theological work of Bruce Morrill elucidates how the sacramental-liturgical life of the church not only facilitates a renegotiated meaning to life but also leads to healing—a deeply theological understanding of healing that technology and medical interventions cannot produce.

**Liturgy and Healing**

American Jesuit theologian Bruce Morrill engages the sacramental theology of Chauvet to apply it to matters of life, illness, death, and healing.434 His central claim is that the enacted liturgy of the reformed rites not only celebrate and embody the Christian faith, but they also engage the worshipping believers in experiences of healing. This assertion may appear at face value to be quite bold were it not for a shared etymological root between the words “health” and “salvation.” Both stem from the Latin *salus*, which relates to the English word “salve” referring to a healing ointment or the action of soothing wounds.435 Morrill’s insight to build upon the etymological connection between salvation and health advances a sacramental-liturgical theology that has important implications for health care and palliative care teams in particular. The connections can

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434 Bruce Morrill, *Divine Worship and Human Healing*.
435 Susan K. Wood, “The Paschal Mystery: The Intersection of Ecclesiology and Sacramental Theology in the Care of the Sick,” in *Recovering the Riches of Anointing: a Study of the Sacrament of the Sick*, ed. Genevieve Glen (Collegeville, MN: Liturgical Press, 2002), 5–7. Furthermore, Wood notes that terms similar to salvation such as “redemption” and “justification” are tied respectively to metaphors of economics and law or forensics. These related theological concepts and their accompanying metaphors could lend themselves to an interpretation of sacraments that too closely leads back to a mechanical perspective.
best be made when one sees sacraments as encounters with the healing-saving presence of Christ Jesus. This first entails shedding the instrumental perspective that sacraments are signs.

Morrill critically assesses the instrumental view of sacraments for its “all but exclusive identity of the church with the priest to the neglect of Christ's liturgical presence in the active participation of all the faithful assembled.” This parallels an instrumental or technological view of medicine that exaggerates the role of the physician. The priest follows the sacramental rubrics to confect the Eucharist thereby “giving” grace to the faithful, and the physician follows the standards of care to fix and give the patient a new knee or repair a heart valve. In this model, “a sacrament is a supernatural instrument delivering a guaranteed product rather than a revelatory sign engaging the participants in a way that changes their perception of themselves and their world.” A change in perceiving the Christian sacraments—from mechanically productions of grace to healing encounters with Christ—can spark a similar change of perception in regarding the capabilities and expectations of medicine and society’s healthcare system. This interconnected relationship between the sacraments and medicine is possible because both pertain to healing.

Bernard Häring had expressed similar discontentment over a dichotomy he saw between sacramental ministry and the healing ministry of the Church. He contends that the church’s saving mission should extend itself to all levels of human relations, regardless of whether they are healthy or in need of healing. He writes, “People’s health,

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436 Morrill, *Divine Worship and Human Healing*, 19. The author draws attention to the vision in *Sacrosanctum Concilium* which calls for the full, conscious, and active participation of all (§14) as the key priority in the restoration and promotion of the liturgy which significantly influenced both the scholarship and pastoral development of the liturgy.

437 Morrill, 20. See also Chauvet, *Symbol and Sacrament*, 7-45, 128-140.
their capacity to open themselves to all dimensions of the messianic peace and to commit themselves to spreading the gospel of peace and salvation, has much to do with the Church’s ministry of salvation and its integration of revealing and healing.”

Häring tasks local pastors to see themselves as more than “producing the sacraments.” Parishes ought to care for the “wholeness and health of individuals and of the civic community.” The proclamation of salvation must be accompanied by a holistic sense of health in one’s life.

At the heart of the argument for both Morrill and Häring is a distinctive understanding of healing that differs from curing. Morrill defines healing as “a matter of transforming people’s perceptions of a critical or painful situation by making it somehow meaningful. Healing in some way invokes Christ, especially his death and resurrection, and these [are] paradigmatic of his service to others.” While Morrill offers several related definitions of healing throughout the work, he consistently returns the theme of a renegotiated meaning applied to sickness of any kind. Renegotiating an understanding of sickness begins to confront the idea and ever-pervasive hope for a cure. The process of renegotiation applies not only to physical sickness, but also to every type of brokenness in the world. Furthermore, this renegotiation applies not only to men and women living with illnesses, but also to spouses, children and all family

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439 Ibid. Emphasis original to the author.
440 This distinction is particularly helpful for those involved in healthcare ministry in the U.S., as the *Ethical and Religious Directives* also delineates differences. It posits that even when medicine cannot cure, the task before medicine remains to offer care. See, ERD, Introduction to Part Five.
441 Morrill, *Divine Worship and Human Healing*, 31. As paradigms of Christ-like service, these constitutive elements of Christian healing ought to be the focus for those engaged in the healing ministry of the church.
442 Morrill offers definitions and explanations of healing throughout the work and often connected to pastoral situations or biblical exegesis (Ibid., 75, 81, 95–7, 172–3).
443 A cure can generally be understood as the indefinite arrest of a disease progression, if not the complete removal of disease from the body (Ibid., 75).
members, caregivers, a loving friend, physicians, and all professionals within healthcare. Just about everyone at some point in life will confront the need to renegotiate an understanding of sickness and human flourishing. As Häring taught us, “We shall heal what can be healed and give, or rather uncover, the meaning in what cannot be healed.”

We do this for ourselves and when confronting the illness of a loved one. If we see the liturgy as the “work of the people,” in which they encounter the saving, or rather, healing actions of the living Christ, then the sacramental-liturgical life of the church holds the power to bring about healing and hope, not just for the physically sick, but for all who believe.

Changing one’s perception of self, world, and healing, necessarily changes one’s relationship to and expectations of medicine and society’s healthcare system. The medical intervention offered by palliative care specialists is a conversation that aims to understand the patient’s need and then reshape his understanding of how medicine will support his most important goals and desires. Unlike a surgeon who employs a scalpel or an oncologist who relies upon chemotherapy and radiation, a palliative care physician relies upon in-depth conversations with the patient. Stated differently, the basis of palliative care is an encounter. It is an encounter that cuts to the heart of the patient’s being and not merely the ailments of a non-functioning body part. The patient’s conversation with the palliative care team may force a renegotiation of all the other roles of the medical team vis-à-vis the patient’s wishes and values. Moreover, it may also serve to refocus the patient’s perceptions of healing in place of curing and also reorient his hope. For example, the patient with an inoperable and aggressively growing cancerous tumor may come to realize that hoping for a medical cure is unrealistic. His

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experience of healing, however, may be living long enough so that he can reconcile with his mother or with an estranged sibling. And hope, for him, may be transforming his once-held hope for a medical breakthrough to the hope that he can manage his symptoms long enough to attend his granddaughter’s graduation, or the hope of witnessing to his family what a good death can look like.

Morrill argues that when one embraces this distinction between healing and curing, then decisions regarding particular medical therapies and interventions may in fact reflect this difference. Morrill’s argument that the sacramental-liturgical rituals fundamentally change in one’s perception of healing, impacts the horizon of things for which one hopes. In other words, for those who engage the sacramental-liturgical rituals—patients, family members, physicians, healthcare professionals, etc.—their experiences of healing can vastly augment their understanding of what it means to provide care to sick patients. As a focal practice, the sacramental-liturgical rituals more readily open up alternative perspectives of healing unconstrained by technology. Dislodging sacraments from the view that they are instrumental grace dispensers, can in turn affect a similar change of perception of medicine, illness, and wholeness, and healing.

At their core sacraments are not primarily about getting something. I share Morrill’s assessment that they are “about being more deeply aware of oneself and others as the very site of the loving faithfulness and gracious mercy of God, in whatever condition we find ourselves.”  The worshipping body encounters Christ in the liturgy, and the individual believers are thereby offered the opportunity to evermore deeply be formed and healed by Christ’s own life. This process of metanoia, or divine healing, is

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445 Morrill, Divine Worship and Human Healing, 17. Emphasis original to the author’s text.
marked by three liturgical characteristics that enable healing; the scriptures, a community of faith, and the paschal mystery, which implies a pneumatological dimension. Each deserves detailed exploration.

Three Characteristics of Sacramental-Liturgical Healing

The Scriptures

The Second Vatican Council taught that that when the scriptures are proclaimed in the liturgical action, it is Christ who is truly and presently speaking to the assembled Body. Members of the assembly, themselves a presence of Christ in their gathering, move deeper into their Christ identity when hearing and receiving the scriptures proclaimed. As described above, the scriptures recount God’s saving and faithful activity in the past. Proclaiming the stories of salvation and actively receiving and pondering them renews the faith of the gathered assembly and nourishes their hope that what God has done in the past, God will again do for them.

At the beginning of the journey toward Emmaus the Risen Christ Jesus interprets the scriptures for the two disciples. This began the process of healing the blindness of their faith. The scriptures were a necessary and foundational component of healing. At the heart of the Gospels is the narrative of how the Divine enters into the volatility and vulnerability of human history with all its sickness, brokenness, and sin. Jesus, the incarnate and eternal Word of God, embraces suffering with divine love and saves us by

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446 Sacrosanctum Concilium, §7, See also Chauvet, The Sacraments, 43–49.
dying on the cross and being raised to life in the Spirit. Morrill describes how the scriptures break open the particularity of the historical content of Jesus’ life and liberating love. He argues for its importance when he writes:

To insist on history as the medium of God’s redemptive work is to accept the sometimes consoling, other times unsettling revelation that, like Jesus, we meet God in the concrete circumstances of our own lives, both as participants in various social bodies and in the waxing and waning of our personal bodies. For such was Jesus’ life story unto death, empowered by the Spirit of God who raised him from the dead and thereby revealed the divine presence in a life spent in self-sacrificing love for fellow humans. The risen Christ’s gift of the Spirit sets the lives of believers in the same pattern of encountering the unseen God in the concrete circumstances of their own time and place.\(^4^4^9\)

Relying on the scriptures as an essential component of sacramental-liturgical actions, believers take hope and consolation that God’s grace communicated through the body and the person of Jesus will likewise flow through the bodies of men and women today. For their part, the scriptures help believers to see with new eyes the patterns of God’s mystery, love, and grace that is continually operative in the world.\(^4^5^0\) It appears that Dame Saunders knew the healing power of God’s word, as she reflected on the daily readings and for a time, wrote her own prayer reflections based on them.\(^4^5^1\)

**Community**

Healing involves more than the individual; it entails community. Sickness is not merely an individual affair. It alters the sick person’s social location, relationships to the wider community, and relationships with spouses, children, friends, and wider family. I highlighted this aspect in the working definition of palliative care. The importance

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\(^4^4^9\) Morrill, *Divine Worship and Human Healing*, 111.
\(^4^5^1\) Du Boulay, *Cicely Saunders*, 76.
palliative care places on maintaining relationships and the patient’s ties to the community can be supported by the communal dimension of the liturgy.

The healing enacted by Jesus entailed restoring the individual to the community. In the Emmaus story, two disciples left their circle of friends in Jerusalem. After experiencing Christ in word and sacrament, “that same hour they got up and returned to Jerusalem; and they found the eleven and their companions gathered together” (Lk 24:33). Luke’s account of this sacramental moment concluded with the two disciples uniting with the community. In other biblical passages involving bodily or mental illness, the same pattern is operative. The woman suffering from hemorrhages “could not remain hidden” (Lk 8:47). She reveals her identity to Jesus and to “the presence of all the people” (v. 47). Jesus tells her, “Daughter, your faith has made you well; go in peace” (v. 48). Despite what must have been her fear and experience of shame for her illnesses, Jesus’ healing-saving action gives her peace. In the story of the Gerasene demoniac, the man appears to be among the most despised and rejected of all social outcasts as he has nowhere to live but among the dead (Mk 5:3). After healing him, Jesus tells the man, “Go home to your friends, and tell them how much the Lord has done for you” (v. 19). The man shares his experience not only with friends, but with all in the Decapolis (v. 20). The healing effected by Jesus Christ moves the individual out of isolation and into a deeper connection with others.

The Gospels reveal that the healing that comes from Divine love surpasses a narrowly construed mindset of a biomedical cure. Such healings involve not just the sick person, but also family and others who may have also quietly been “seeking meaning,  

confidence, hope, faith, and with these, forgiveness. Morrill sees a powerfulness behind such healing as it “causes all to renegotiate their understandings of and relationships among each other and God. The promise of healing, nonetheless, comes through the process of change (metanoia), repentance and release from habits, decisions, and (in the case of the social and political body) customs and policies that can bind persons chronically in illness.

Healing, understood through the biblical world and therefore in the ongoing presence in the sacraments, involves an attentive concern that surpasses medicine’s practice of singularly focusing on one particular bodily system or function. Clinical standards of care do not suffice for a sense of healing motivated and informed by the Gospels. This same concern for the relational dimension of the patient played an important role in the formation of St. Christopher’s. Dame Saunders showed concern to the communal aspect of care as she wanted the vulnerably ill to see and realize that they were not alone in their journey.

Morrill’s observation that the Gospel healings instigate metanoia and pose a challenge to socially constructed customs and policies, bears import for palliative care. It can aid and support palliative care in its efforts to use the art of medicine differently from that of other medical professionals. As we have seen, palliative care restrains its confidence in and use of technology. The lung cancer study demonstrated that when palliative care specialists challenged the customs and established medical policies for lung cancer treatments, it led to something akin to this notion of healing that Morrill describes. Recall that patients in the lung cancer study who received palliative care

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454 Morrill, Divine Worship and Human Healing, 89.
455 Ibid.
notably had decreased experiences of pain and depression. Maintaining good levels of mood for patients enables them to more fully engage with their family and loved ones. It allows them to focus their energy on the activities they most enjoy rather than exerting what little energy they have on getting to the clinic for a medical treatment, and thereby leaving them with little or no energy to share with the people who matter most to them. It also makes possible the individual’s own healing as it touches the individual’s identity.

The definition of palliative care included attention given to the lives of those men and women who are important to the patient. The Gospels reflect this exact dynamic. The healing enacted by Jesus drew the sick back into communion with others. A similar dynamic occurs when the faithful gather to enact the saving mysteries of Christ. The gathered church, the people of God, come to the sacramental-liturgical rituals with all their lives, their joys and excitements, and their pains, struggles, and anguish. Some come with an aging parents using canes and walkers, while others come having just reached a life milestone or a long-desired career promotion. Still others come with children born with disabilities or having learned that a spouse or sibling has been diagnosed with a chronic or terminal illness.

By gathering as the church, the living Body of Christ, the sick see that they are not alone in their journey and their search for wholeness and hope. A sacramental gathering that includes the sick differs from a community of people living together with their illnesses and enjoying visits from family and friends. In the sacramental-liturgical gathering, the ill with their loved ones and the whole community of faith, gather before the living presence of God made present through Christ and the Spirit—the One who alone can heal their every ill.
One final point regarding community is needed. Often neglected is an attention to how the presence of the sick impacts the wider community. The scriptures say little to nothing about how the community responds when the man once known as the Gerasene demonic returns to town, just as we learn nothing of how the community responds to Lazarus raised from the dead (John 11:43–44). The presence of those needing healing serves as an opportunity for an unanticipated breakthrough of grace for those in the worshipping body experiencing a fuller sense of health. Moreover, the rituals help the sick, healthcare professionals, and the gathered assembly experience faith and hope even in the presence of illness and disease. Jürgen Moltmann describes how the presence of those with disability confronts those of us who are more able to face our humanness and our own sense of weakness, dependency, and flourishing. I am often moved when I see a person using a mobility device such as a walker or a wheelchair approach the altar in the eucharistic procession. Or, when I know someone enduring cancer treatments or some unseen illness and I see them approaching the altar of the Lord to partake of the Body and Blood of Christ, I see Christ sharing in their suffering and offering them comfort by divine accompaniment. I once worshipped in a community where the end of the communion line often included an elderly man with an awkward limp and a large scar across the side of his head. I never knew his name, his story, or his medical history. He

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456 Edward Foley, “Eucharist, Postcolonial Theory, and Developmental Disabilities: A Practical Theologian Revisits the Jesus Table,” *International Journal of Practical Theology*, 15 no. 1 2011, 57–73. This point, of course, applies only for those individuals whose disability or sickness is visually apparent to others. Millions of people suffer with mental and unseen physical diseases that should not be ignored, and my comment should not be read as an insensitivity to their suffering and the benefit of the sacramental practices on their lives. Most likely spouses, siblings, children and other close members of the family know of these unseen sufferings, and they too can be moved and graced by seeing their loved one engaging the healing-saving mysteries of the church.


shuffled his body slowly down the center aisle to say “Amen” to the crucified and risen body of Christ living and present in the Eucharist. As we sang a hymn referring to “this living bread of God,” I could not help but think how much this man likely hungers for this living bread and how some day, and when I experience a greater sense of (dis)ability, I too will also lean toward this living bread for my own healing-saving needs. These sacramental experiences also remind me of my own Christian calling to patiently and lovingly share in the sufferings of others. Morrill, for his part, reflects how he had been moved and changed in an experience of sharing the sacraments with a homebound elderly woman.459 Yet much more work can be done by liturgical theologians to study and to aid pastors in leading parish catechesis and reflection on how the presence and the participation of the sick and the vulnerable impact the worshipping community.

The Pneumatological Dimension

Lastly, the sacramental-liturgical life of the church necessarily involves a pneumatological dimension. From the onset of this present work I described the paschal mystery in terms of the incarnation, life, death, and resurrection of Christ Jesus. Yet, the paschal mystery implies the active presence of the Spirit of God—the Holy Spirit who overshadowed Mary when she learned she was to give birth to the Son of God (Luke 1:35), the Spirit that descended upon him at his baptism in the Jordan (Mark 1:10), the Spirit Advocate that Jesus promises will be with his followers until the end of time (John 14:15–17, 25–26), the Spirit that Jesus gave over to the believing community when he died (John 19:30), and the Spirit of Pentecost that enables the believing community to

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continue his ministry until he comes again (Acts 1:2, 8). The Spirit’s presence permeates every aspect of the paschal mystery and hence the sacraments themselves.\textsuperscript{460}

The scriptures portray the Holy Spirit as the Spirit that creates and raises to life. It is the Spirit that unpredictably blows where it wills (John 3:8), an image that stands in stark contrast to the technological view that all but guarantees that if the right button is pressed, or the proper device is activated, the result will be reliable, effective, and predictable. An ongoing encounter with the Spirit of God in and through the liturgical rites can form the worshipping believers in a view and pattern of life different than that of technology. The Spirit, the Advocate, invites the believers into a relationship of trust in God’s fidelity and covenant to always and forever abide with God’s people. This is important for those with chronic and terminal illnesses who may fear many things: the unknown, the loss of control, vulnerability, and increasing sense of dependency and burdensomeness, abandonment, the process of dying itself and more.

The pneumatological dimension of the sacraments aids palliative care for both those who receive it and those who are its practitioners. For patients, the Spirit that is active and present in the sacramental-liturgical rites can lead them into a faith and hope that God will be ever close and present to them throughout the duration of their illness and at the hour of death. As sacramental theology demonstrates, that presence of God is not a nebulous, far-off presence, but an intimate, active, and living presence in word and sacraments that continues through the lives of the members of the Body of Christ today.

As for practitioners of palliative care, the presence of Holy Spirit active in the sacraments

\textsuperscript{460} Chauvet stresses that in addition to the traditionally Christocentric focus of the sacraments, they also possess a necessary pneumatological pole. He observes that every sacrament entails an epiclesis, a detail that further evidences an integral role of the Spirit. See, Symbol and Sacrament, 509–530, and The Sacraments, 164–169.
keeps alive their ministry of care as an essential ministry of the living Church. As Morrill writes, “the risen Christ’s gift of the Spirit sets the lives of believers in the same pattern of encountering the unseen God in the concert circumstances of their own time and place.”\textsuperscript{461} It breathes life into their work and profession, urging them on as the inheritors and living embodiment of Jesus’ ministry in the world today.

**Summary**

To this point, I have examined a contemporary understanding of sacraments influenced by the theology of the Second Vatican Council. I argued that they are best understood as gift-exchange, defying the logic of market exchange and the characteristics of efficiency and effectiveness that mark both medicine and technology. A life formed by the sacramental-liturgical life of the church enhances the practice of palliative care because they both share a vision of healing that does not necessitate a cure. They both look beyond the use of technological deployment in their efforts to heal.

To more concretely describe and envision how the sacramental-liturgical life of the church enacts healing and thereby serves as an important component of palliative care, I next explore the rites of baptism and Eucharist. I hope two points will emerge in this discourse. First, these two sacraments form the foundation of the Christian life and most clearly witness the fundamental pattern of the paschal mystery. As such, they communicate a particular interpretation of the human experience of death. Like palliative care, they do not view death itself as the ultimate enemy. They can support the practice of palliative care by the way they form Christian believers to see the experience of death.

\textsuperscript{461} Morrill, *Divine Worship and Human Healing*, 111.
through the mystery of the resurrection. Secondly, as a result of the Christian view of death, these sacraments communicate and cultivate the virtue of hope. Such hope contrasts with the hope that is usually experienced in the technologically saturated medical environment, which is a hope for a remedy for one’s experience of illness. As Häring states, together “we can heal what can be healed and bear the rest in Christian hope.”\textsuperscript{462} In other words, the depth of Christian hope exceeds that of medicine, or rather, any hope of human origin. Christian hope remains when all other human hopes have burned away. When disappointment sets in, when hearts are crushed when learning that death is invading one’s body through a rampant tumor, and when dreams of a new home, a new opportunity, or long-awaited get-away smash against the reality of a tragic, life-altering incident and all hope seems lost, the Christian virtue of hope hangs on. Moreover, the liturgy is the primary place where this hope is experienced and received. By examining particular aspects of the sacraments of baptism and eucharist, I hope it will become clearer how the sacramental-liturgical life of the church enables men and women to bear their illnesses and experiences of pain with trust and hope.

\textbf{Part III: Healing and Hope — Baptism and Eucharist}

Before examining some aspects particular to the sacraments of baptism and Eucharist that exemplify their healing qualities and foster Christian hope, I must first explain why I have not chosen the sacrament of the anointing of the sick. After all, most Catholics associate the sacrament of the anointing of the sick as the one, if not exclusive, sacrament of healing. Traditionally, the church categorizes the sacraments of penance

\textsuperscript{462} Häring, \textit{In Pursuit of Wholeness}, 74.
and the anointing of the sick as the sacraments of healing. Narrowly confining the
healing nature of the sacramental-liturgical life of the church to just the anointing of the
sick presents several problems. As Susan Wood persuasively argues, the roots of the
healing nature of this sacrament come from its close identification with baptism and
eucharist, and this should be stressed over the fifth sacrament’s association with the
sacrament of penance and the forgiveness of sins. She explains:

> Both baptism and Eucharist essentially celebrate the same mystery, for when all is
> said and done, there is really only one Christian mystery, the mystery of Christ
dead and risen. Both sacraments recall the death of the Lord. Both baptism and
>Eucharist are sacraments of reconciliation. Both are sacraments of communion
>with the Church. Both are sacraments of the body, both the body of Christ and
>the body of the Church…. When the anointing of the sick is seen in the light of
>these foundational sacraments, we interpret the meaning of illness in the light of
>Christ’s death and reconnect the experience of the individual with the life of the
>Church.  

Connecting the life and experience of the sick and dying with that of the life of Christ,
especially his paschal mystery, is precisely that which I have been advocating ought to
ground the practice of palliative care. This is especially true within a Christian-sponsored
healthcare ministry.

There are others, such as M. Therese Lysaught, who argue for the sacrament of
the anointing of the sick to serve as a radical theological hermeneutic, if not the very
starting point for a theological ethical engagement of medicine. I contend that any
starting point for a Christian theological ethic must first seriously contend with the

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463 Susan K. Wood, “The Paschal Mystery: The Intersection of Ecclesiology and Sacramental
anointing of the sick ought to be the very starting point for a theological engagement of medicine is made
explicit on p. 188. See also, M. Therese Lysaught, “Patient Suffering and the Anointing of the Sick,” in On Moral Medicine: Theological Perspectives in Medical Ethics, ed. M. Therese Lysaught and Joseph J. Kotva,
Christian identity given at baptism and sustained by the eucharist. A highly idealized view of the sacrament of the anointing of the sick as posited by Lysaught dodges a number of serious problems. First, in the Catholic tradition the sacrament of the sick is available only after one has become incorporated into the living community of Christ’s body, at the very least through baptism, if not also through the fullness of the initiatory rites that further include confirmation and eucharist.

Second, as Wood pointed out, all the sacraments, insofar as they are sacraments of salvation, pertain to healing. Without a deeper understanding of how baptism and Eucharist enact healing, any theology of anointing of the sick limps. The Prenotanda to the Pastoral Care of the Sick also reflects a primacy of the Eucharist over the sacrament of anointing of the sick. It stipulates that the sick and those preparing for surgery should receive the sacrament of anointing of the sick. The Prenotanda, however, imposes an obligation to receive and participate in Eucharist. It states, “All baptized Christians who are able to receive communion are bound to receive viaticum by reason of the precept to receive communion when in danger of death from any cause.”

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466 The Rites, “Introduction,” §10, p. 584. One problem that arises is the antiquated view of medicine within this text. Surgery is a broad term referring to a number of medical procedures, some of which are very common and minimally invasive. While surgery always has risks, such as infection and the possibility of death, numerous innovations have made surgery vastly more common with markedly decreased risks.

467 The Rites, “Introduction,” §27, p. 588. Emphasis added. The previous paragraph notes, “When possible, viaticum should be received within Mass so that the sick person may receive communion under both kinds. Communion received as viaticum should be considered a special sign of participation in the mystery which is celebrated in the eucharist: the mystery of the death of the Lord and his passage to the Father” §26. The request to receive communion “within Mass” is important as it avoids an instrumental view of the sacrament, as does the preference to receive both the body and blood of Christ, and not just the former.
Eucharist is one that medicine and Catholic healthcare in particular must explore and understand.

Third, among a number of concerns related to Wood’s perspective, Gisbert Greshake implies that the post-Vatican II shift away from “Extreme Unction” may in fact implicate the Church as perpetuating the social and medical denial of death. The Council’s widened view of the fifth sacrament loosened its connection to a baptismal renewal in the face of death. By encouraging the anointing of the sick for just about any illness, the revised rite suppresses and undermines the significance of death. It impoverishes the rich Christian understanding of hope beyond death. Fourth and relatedly, while the Council endeavored to respond to contemporary pastoral needs, pastoral and theological aspects of the sacrament of the anointing of the sick have struggled to keep pace with the rapid advances in scientific medicine’s capabilities and the unending changes in healthcare. Lizette Larson-Miller similarly acknowledges

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469 Gisbert Greshake in “Extreme Unction or Anointing of the Sick? A Plea for Discrimination,” Review for Religious 46, no. 3, (May-June, 1986): 435–452, writes, “Would it not be a service of the Church to contemporary man [sic] to confront him with the reality of death and dying, i.e., the reality of death in the wide expanse of lies, half-truths and vain promises, and to make him conscious of the pathos of worldly utopias, through a sacramental praxis that places man ‘in the presence of his own death’?” (Ibid., 445). The intent, Greshake maintains, is to arouse hope as the believer confronts the seriousness of her own bodily death. He notes how ordinary experiences of illness “do not present such a crisis in which man [sic] is irrevocably placed ‘before his death.’...Thus, it is my opinion that it is...a perversion of the purpose of the sacrament, to administer it to the type of sick persons who are not in fact confronted with death. Precisely in light of the modern social trend to repress death, the praxis of a sacrament ‘facing death’ would certainly be more appropriate to contemporary era” (Ibid., 446). He calls for this sacrament to “medicate hope and joy in the face of death. Seen in this way, this sacrament brings to completion that toward which we are on the way: the community of life with the dying and rising Lord who is our hope” (Ibid., 450).

470 Kristiaan Depoortere lucidly articulates many layers of problems in “Recent Developments in the Anointing of the Sick,” in Illness and Healing, ed. Louis-Marie Chauvet and Miklos Tomka, trans. John Bowden, (London: SCM Press, 1998), 89–100. Some readers may be surprised by Depoortere’s critique of liturgies where the anointing of the sick takes place in large communal settings. He reasserts the critique raised by Greshake that it can deny those who are sick of a substantive rite of passage when they are “objectively and subjectively confronted with the possibility of dying” (Ibid., 98). I share his concerns of the practicalities—most of which, if not all, are medical and technological—that impede and all but strip
“new and disturbing questions” that have surfaced in recent decades because of the way people die in our healthcare system. More clearly than other authors, Larson-Miller’s careful analysis of the details of the anointing rite reveals how the sacrament can easily be perceived in the instrumental and mechanical mode described earlier in this chapter.

A final problem with using the anointing of the sick as the paradigm for a Christian engagement of medicine is its lackluster ecumenical appeal. Not all in the Christian family view this ritual as a sacrament. More pertinent to this current work focusing on palliative care is the fact that Eucharist factored into Dame Cicely Saunders’ vision of St. Christopher’s Hospice, not the anointing of the sick. The latter certainly holds its own important place in the Catholic sacramental tradition, but its shortcomings away the sacramental richness that once accompanied viaticum. I also share his view that newly created “blessing of a dying person,” is not only dissatisfying but also wholly inadequate (Ibid., 92–93, 96–97).

Uniquely among the Christian liturgical traditions, the Episcopal Church in the United States has taken note of the tremendous changes in healthcare and responded to the increasingly common experience of a prolonged dying process as “a pastoral opportunity to share that journey.” To that end, they commissioned supplemental liturgical materials that have been approved and officially recognized, which include a prayer for “When Life-Sustaining Treatment Is Withheld or Discontinued.” The rite includes collects, scripture, a litany with tropes and language specific to the situation, a laying on of hands and possible anointing, reception of the Eucharist, including a prayer ritual for the sick person who desires but is unable to receive communion in the mouth, and closing collects with options for health care providers, all who suffer, and the one for whom treatment is to be withheld or discontinued. The Standing Commission on Liturgy and Music, *Enriching Our Worship 2: Ministry with the Sick or Dying, Burial of a Child* (New York: Church Publishing Incorporated, 2000). See especially, p. 6, 117–127.

471 Lizette Larson-Miller, *The Sacrament of the Anointing of the Sick* (Collegeville, MN: Liturgical Press, 2005), 123. She writes, “The central and delicate balance at the heart of so much of the Anointing of the Sick was to clarify for whom the rite was designed (the seriously sick, not the dying), which at the same time trying to articulate who was sick enough for the sacrament (the seriously sick, not just any sick). Into the midst of that discussion comes the growing reality of the modern way people die in intensive care units, lingering longer and perhaps more conscious of being in the dying process… How will the changing world of medical technology and cultural ideas of appropriate spirituality and ritual challenge, prod, or confirm the rites for the sick? Much in the rites remains solidly helpful and life-giving, and much work remains to continue the constant adaptations and reflections that keep the rites as living liturgy for the next generation” (Ibid., 123–124). Larson-Miller concludes her work with these lingering and unsettling questions, while offering scant suggestions beyond gesturing toward the need for adaptations. Notice how these very questions regarding who should be anointed and when, shift the attention to a mechanical view of the sacraments. This obscures the more important work of meditating on what God is doing to us through this sacramental encounter.

preclude it from best exemplifying how the sacramental-liturgical life of the church can lead to healing and hope.

For this present work, I draw from Wood’s insight that healing, foremost and fundamentally flows from the sacraments of baptism and Eucharist. Aidan Kavanaugh’s seminal work makes a similar point. He writes, “in baptism the eucharist begins, and in the eucharist baptism is sustained. From this premiere sacramental union flows all the Church’s life.”⁴⁷³ He also states ever more clearly that “all other sacraments…find their meaning and purpose only within this ‘economic’ context. Christian’s rights, privileges, and duties originate here. Here the Church’s mission is constantly being set at the most fundamental level…. Initiation defines simultaneously both the Christian and the Church, and the definition is unsubordinated to any other except the gospel itself.”⁴⁷⁴ As Kavanaugh suggests, baptism and eucharist, although they are sacraments of initiation are also more than that! They form the very contours of Christian identity, an identity I contend can make a significant difference for those receiving as well as those practicing in palliative care. Like Morrill, I believe it in-forms an understanding of healing.

Thus, in what follows, I examine the healing dimension of these two sacraments. Baptism incorporates us into the life of Christ and sets in motion our participation in the paschal mystery. Eucharist nourishes us in that journey—it provides an ongoing, dependable encounter with the saving-healing presence of Christ. The two sacraments

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⁴⁷³ Aidan Kavanagh, *The Shape of Baptism: The Rite of Christian Initiation* (New York, Pueblo Publishing Company, 1978,) 122. This quote by Kavanagh summarizes the preceding line of thought whereby he writes, “The Rite’s norm of baptism thus rests on the economic principle that baptism is inadequately perceptible apart from the eucharist; that the eucharist is not wholly knowable without reference to conversion in faith; that conversion is abortive if it does not issue in sacramental illumination by incorporation into the Church; that the Church is only an inept corporation without steady access to Sunday, Lent, and the Easter Vigil; that evangelization is mere noise and catechesis only a syllabus apart from conversion and initiation into a robust ecclesial environment of faith shared,” (Ibid., 122).

⁴⁷⁴ Ibid., 145.
are not only important but also foundational because they so prominently feature the three liturgical characteristics that enable healing, namely scripture, the community, and the paschal mystery. As I examine specific parts of these two sacraments, I will draw attention to how both support palliative care’s efforts to thwart medicine’s perception that death is the enemy and to be avoided at all costs.

**Baptism – Dying with Christ Who Saves Us in Hope**

The Christian renegotiation of what it means to be human and how we find meaning in our experiences of illness, debility, death, and new life, most substantively begins with the Christian sacrament of baptism. Like a doorway, baptism opens up believers to an eschatological horizon of hope and initiates men and women into the life of the triune God who heals and saves us. In what follows I offer a limited interpretative analysis of baptism along with theological reflection of how it can impact palliative care. First, I draw attention to the elements of the Creed professed in the baptismal rite. Next, I engage in an exegesis of Romans 6:1–11 where the Apostle Paul relates Christian baptism to the death of Christ Jesus. This provocative imagery ought to shape any Christian understanding of illness and death. Finally, before leaving baptism aside to consider some pertinent aspects of the Eucharist, I draw from Pope Benedict XVI’s encyclical *Spe salvi*, which connects baptism to hope and ends by implying the importance of the Eucharist as a means to further enrich the individual Christian’s experience of the virtue of hope.
The Interrogative Creed

In the RCIA the candidates for baptism profess the faith in which they are about to be baptized\(^475\) by responding to three questions from the Creed posed by the priest celebrant.\(^476\) In the first question, they affirm belief “in God, the Father almighty, creator of heaven and earth.”\(^477\) This affirmation professes the candidates’ belief that reality entails something beyond the earthly, namely the existence of a heavenly dimension. This is an important component for a theological reflection on palliative care because the technological realm, as Heidegger averred, ended metaphysics and pertains only to what is effectively and efficiently possible here and now in the world before us. Professing a belief in the heavenly ought to be concretely lived out in the medical decisions Christians make. The next two questions in the Profession of Faith crystalize this point.

The second question to the candidates for baptism probes further when they are asked about the relationship between the human family and the heavenly realm. Answering affirmatively to the second question posed in the profession of faith signals that the soon-to-be-Christian believes that at least one from the human family, namely Jesus, has fully experienced human death as he “died and was buried.” Yet, that death

\(^{475}\) Paul Bradshaw argues that a liturgical recitation of the creed as part of the baptismal event had the effect of changing the implied character of baptismal faith from an act of personal commitment to Christ to belief in a body of doctrines as a necessary prerequisite for baptism. See, Paul F. Bradshaw, “The Profession of Faith in Early Christian Baptism,” Evangelical Quarterly 78, no. 2 (2006), 107 among 101–115.

\(^{476}\) Adult baptism is presumed to be the norm from which other adaptations arise, most notably, the Rite of Infant Baptism. In other words, like the Rite itself, I am presuming that the individual to be baptized can speak for herself. This differs from infant baptism whereby the parents accept the responsibility for raising the child in the practices of the faith, a detail that raises theological complexities beyond the scope and relevance of this present work. See, Kavanagh, The Shape of Baptism, 105 and 109. Adult baptism also implies the immediate celebration of the Rite of Confirmation as the rubrics mandate. This current work will not address the conundrum created by the Church’s theology and pastoral practices related to the sacrament of confirmation. This has best been sufficiently addressed by Paul Turner in Confirmation: The Baby in Solomon’s Court (New York: Paulist Press, 1993).

\(^{477}\) The Rite of Christian Initiation for Adults, in The Rites of the Catholic Church, §219, p. 99.
was not definitive as he “rose from the dead and is now seated at the right hand of the Father.” I will return to this notion of Jesus dead, buried, and risen from the dead in the following section examining Romans 6:1–11. The basic point however, is that the candidates for baptism assert their faith in the paschal mystery and therefore, they assert that human death is not a final endpoint. The challenge for them becomes living this out concretely when they are faced with difficult decisions regarding their medical care. The seed to courageously face decisions that will impact their death has been planted in baptism. Then, other aspects of Christian living will be necessary to nurture this new gifted aspect of their lives through the eucharist, personal prayer, and the cultivation of virtuous living.

The third and final question posed in the Profession of Faith further probes the candidates’ belief that other men and women participate in this experience of being raised from the dead and therefore enjoying everlasting life in heaven. They affirm their belief “in the Holy Spirit,” the one who creates and raises to life; “the holy Catholic church,” a living community of men and women where God’s saving-healing action continues in the world; and “the communion of saints,” those men and women who have died and whom the church acknowledges as living in heaven and enjoying the fullness of the beatific vision. What is more, the candidates affirm their belief in “the forgiveness of sins, the resurrection of the body, and life everlasting.” These last phrases in the profession of faith are important for those who suffer with chronic and terminal illness and for those who care for them, especially medical professionals. As illness and disease progress throughout an individual human body, it is difficult to see the body lose its functioning.

478 Ibid.
479 Ibid., §219, p. 100.
and gradually deteriorate. At the heart of the Christian faith is the belief that this body will be resurrected, not merely resuscitated. Even more, this life, the earthly life that is fading, slipping through one’s fingers, and slinking away from the loving embrace of family and friends is not the only life. This mortal life is prelude to eternal life. Baptism fundamentally entails the initiation and birth into eternal life. For those who believe this, who believe in “the resurrection of the body, and life everlasting,” then “doing everything” (a phrase often said in a hospital setting when a patient’s body is dying and yet family members ask to exhaust the potential of every medical intervention possible or at least remotely reasonable) medically possible to sustain an individual’s life where health is seriously compromised or actively failing may very well betray one’s core beliefs professed in the ancient creedal statements of the Christian faith. My point is that baptized Christians are fundamentally oriented toward eternal life, and this ought to play a pivotal role in how Christians and their faith-based healthcare ministries understand medicine and its accompanying technologies. Too often, the choices that are made regarding life-sustaining treatments and the discussions concerning care plans in critical care units reflect a stronger, overriding belief that one’s life is fundamentally oriented to the here and now. Patients and healthcare providers alike, clinging to life and the devices needed to sustain it, seemingly operating as if the basic tenets of the Christian faith were stuffed and tied up in the plastic bag along all of the patient’s other belongings and cast away in the closet.

Baptism, however, says something profound about human life and death. Arguably, Saint Paul offers the clearest and most eloquent meditation on the mystery of
baptism and its connection to death and everlasting life in his letter to the Romans.\footnote{The Lectionary describes the book of Romans as a letter (§41, p. 349). Scripture scholars, however, note the difficulty and discrepancy in pinpointing the genre of Romans. Some prefer to describe it as an epistle, a debate sparked a century ago by Adolf Deissmann in \textit{Light from the Ancient East: The New Testament Illustrated by Recent Discovered Texts of the Graeco-Roman World} (London: Hodder & Stoughton, 1910), 218–220. Joseph Fitzmyer and others have questioned and critiqued Deissmann’s distinctions. Fitzmyer prefers to categorize Romans as an essay-letter. Joseph A. Fitzmyer, \textit{Romans: A New Translation with Introduction and Commentary} (New Haven, CT: Yale University Press, 1993), 68–69.} As noted earlier, the scriptures play an indispensable role in enabling divine healing to break through into our lives today and enable a healing which, like palliative care, does not require a cure. The liturgy offers this passage from Romans as the only text from the New Testament at the Easter Vigil, apart from the Gospel itself.\footnote{The Easter Vigil, once described by Augustine as the “mother of all holy Vigils” is noted in the \textit{Roman Missal} as “the greatest and most noble of all solemnities.” \textit{The Roman Missal}, Universal Norms on the Liturgical Year and the Calendar, §21, p. 100 and 330. This indicates its prominence not simply in the liturgical calendar, but more importantly, for the life of the believers comprising the worshipping body. One can logically infer that the scriptures proclaimed during the Liturgy of the Word at the Easter Vigil reflect some of the most foundational aspects for the Christian life.} It merits close attention and some exegetical thoughts.

**Baptized into Death — Romans 6:1–11**\footnote{The Lectionary limits the passage to vv. 3–11. A shorter version of this same passage reappears in the Thirteenth Sunday of Ordinary Time in \textit{The Lectionary} A Cycle of readings. Verses 1 and 2 pose questions that are answered in vv. 3–11. Paul immediately answers the question posed in v. 1, with an elaboration throughout the discourse in vv. 3–11 that expands upon his answer that the baptized Christian ought not to persist in sin just to allow grace to abound. Joseph A. Fitzmyer sees v. 11 as the climatic answer to the question posed at the onset of this pericope. Fitzmyer contends that the latter half of chap. 6 (vv. 12–23) digresses from other parts of the book of Romans, including but not limited to the present chapter. He notes that other scholars identify a division in the chapter (Fitzmyer, \textit{Romans}, 430–432). Craig Hill argues that the second part of the chap. 6 responds to the question in v. 2 and concerns the relationship between the baptized believers and sin. How the baptized are to negotiate the reality of living in a world still wrecked by sin is an important discussion, but less important for my immediate purposes here of drawing out the connection between baptism and dying. See, Craig C. Hill, “Romans” in \textit{The Oxford Bible Commentary}, ed. John Barton and John Muddiman (New York: Oxford University Press, 2001), 1095.}

1. What then are we to say? Should we continue in sin in order that grace may abound?
2. By no means!
   How can we who died to sin go on living in it?
3. Do you not know that all of us who have been baptized into Christ Jesus were baptized into his death?
Therefore we have been buried with him by baptism into death, so that, just as Christ was raised from the dead by the glory of the Father, so we too might live in newness of life.

For if we have been united with him in a death like his, we will certainly be united with him in a resurrection like his.

We know that our old self was crucified with him so that the body of sin might be destroyed, and we might no longer be enslaved to sin.

For whoever has died is freed from sin.

But if we died with Christ, we believe that we shall also live with him.

We know that Christ, being raised from the dead, will never die again; death no longer has dominion over him.

The death he died, he died to sin, once and for all; but the life he lives, he lives to God.

So you also must consider yourselves dead to sin and alive to God in Christ Jesus.  

My purpose for spotlighting this passage is to examine the connections between Christian baptism, death, and the moral life; in other words, to show how it is paradigmatic of the paschal mystery and important to those who receive and practice palliative care.  

Baptism involves death. The beginnings of a Christian life, the birth of

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483 It must be noted that New Testament scholars are divided over the issue of soteriology operative in the Pauline corpus. Some see Paul asserting that believers are justified by faith. Scripture scholars espousing this justification theory include the German Lutheran Ernst Käsemann. See his work, Commentary on Romans, ed. and trans. Geoffrey W. Bromiley (Grand Rapids, MI: Eerdmans, 1980). For a careful analysis of how Romans 6 shaped Martin Luther’s own understanding of justification, see Robert Kolb, “God Kills to Make Alive: Romans 6 and Luther’s Understanding of Justification (1535), Lutheran Quarterly, 12 (1998), 33–56. In addition to the scholars preferring the justification theory are those who see Paul’s soteriology primarily as participationist. A leader of this interpretative method was Albert Schweitzer in his Paul and His Interpreters: A Critical History, trans. William Montgomery (London: A. & C. Black, 1912).

More recently, N.T. Wright’s commanding and breathtaking work, Paul and the Faithfulness of God (Minneapolis, MN: Fortress Press, 2013) firmly stakes out nuanced option that Wright and others describe as the “new perspectives on Paul,” or NPP. For Wright, Christian faith cannot be reduced to where one goes after death. He argues that the Protestant Reformers got it wrong when they pinned justification on grace alone. They were overly influenced by a medieval preoccupation with hell, a theme picked up by Martin Luther. Wright and his fellow NPP scholars contend that Paul focused his preaching and teaching on the absolute faithfulness of God to God’s people. Because God is faithful, the people can trust that God will fulfill God’s promises in history.

484 Some scholars question whether Rom 6 is a baptismal passage. Theresa Kuo-Yu Tsui, in “‘Baptized into His Death’ (Rom 6,3) and ‘Clothed with Christ’ (Gal 3,27): The Soteriological Meaning of Baptism in Light of Pauline Apocalyptic,” Ephemerides Theologicae Louvanienses 88, no. 4 (2012), 395–417, helpfully includes a fine survey of key textual criticisms on this matter. She presents the general
a Christian comes forth from dying. As Christians, we have already died. This can be a powerful and potentially liberating insight from the very bedrock of the Christian tradition for those suffering with terminal illness as well as for those with chronic illnesses and debilitating conditions that will contribute to their eventual death. As a pathology overcomes the human body the experience can be fraught with fear and paralyzing anxiety. This New Testament passage can powerfully support the renegotiation of what it means to be human, to experience health, to die, and to live fully, all of which are constitutive elements in the definition of palliative care.

consensus that the passage is neither primarily about baptism *per se* nor a full Pauline baptismal theology. Rather the passage strengthens Paul’s overall argument that the baptized are to live in a fundamentally new and different way. See especially, 396–398.

Fitzmyer likewise notes how baptism emerges in Rom 6:3–11 as a related topic to Paul’s larger discussion on death to sin and the Christian life of grace. Although the passage does not present a comprehensive baptismal theology, it would be wrongheaded to conclude that this passage says nothing about baptism. Paul offers a significant foundational understanding of what God is doing to us though this sacrament. Fitzmyer contends that this passage represents Paul’s main discussion on baptism among the many other places Paul addresses it, such as 1 Cor 6:11; 10:1–2; 12:13; 2 Cor 1:22 and Gal 3:27–28. Cf. Col 2:11–12; Eph 1:13; 4:30; 5:14, 26; Titus 3:5, (Fitzmyer, *Romans*, 430).


Maxwell E. Johnson *The Rites of Christian Initiation: Their Evolution and Interpretation*, Revised and Expanded Edition (Collegeville, MN: Liturgical Press, 2007). Johnson has authored the seminal and most up-to-date, comprehensive work on Christian initiation, which, broadly outlined, follows the pattern of: first, a rite of separation; then, a time of transition and separation; followed by the Rites of Initiation, which include baptism, confirmation, and first communion; and lastly a period of mystagogy or an explanation of the mysteries. His attentiveness to ecumenical dimensions rings clear throughout. It is reflected in a chapter on initiation in the Protestant and Catholic Reforms of the Sixteenth Century, further evidenced in the revised second edition, which includes a new chapter on the Rites of Initiation in the Christian East, and comes to completion in the final chapter that thoughtfully raises questions and possibilities arising from a common baptismal spirituality. Relating to Romans chap. 6, Maxwell describes this revised edition as reflecting his own newly articulated conclusion that “Romans 6, with some exceptions, was rather new to both East and West as an overall theology and paradigm in the fourth century” (p. xiv; see also, 70–73, 136–149, 155–157). See also, Susan K. Wood, *One Baptism: Ecumenical Dimensions of the Doctrine of Baptism* (Collegeville, MN: Liturgical Press, 2009).
The Apostle Paul asserts the Christian paradox that living fully entails death. Christians have already confronted an experience of death in baptism. This reality for baptized men and women provides them with a familiar perspective, if not a confidence with which they can confront the fear that comes when our earthly existential death approaches. Having died with Christ in baptism, Christians have been given the possibility of encountering a freedom that transcends the gripping fear and pain. Paul preaches, “we have been buried with him by baptism into death, so that, just as Christ was raised from the dead by the glory of the Father, so we too might live in newness of life (v. 4).”

Living in the newness of life is ethics. This passage encapsulates the sacramental perspective articulated by Chauvet that the sacraments lead to ethics. Joseph Fitzmyer argues that this first portion of Rom 6 continues and reinforces a theme that began in preceding chapters. Paul envisions that “Christian life and conduct not only involve the fulfilling of duties, but even demand it. The new life brought by Christ entails a reshaping of human beings.”\textsuperscript{486} Baptism transforms the believer’s very being. This has powerful implications for both patients receiving palliative care and the healthcare professionals who offer it. The reshaping of the lives of men and women by baptism must also entail their experiences and encounters with illness and death. The work of scripture scholars, which I will now examine, draws connections between baptism, death, and Christian moral living.

\textsuperscript{486} Fitzmyer, \textit{Romans}, 429. The transformation is not merely ontological. Paul had previously articulated the integrated Christian life at an ontological level (Gal 2:19–21). Romans raises the transformative process to a cognitive level. Fitzmyer writes, “the physical life that a justified person lives has to be lived out consciously in faith.” He elaborates saying, “for Paul baptism tears a person from one’s native condition (‘in Adam’), from one’s native proclivity (‘in the flesh’), and from one’s ethnic background (‘under the law’). It thus incorporates the person of faith ‘into Christ’ so that one lives ‘in Christ’ and ‘for God’ in order that one may be one day ‘with the Lord’ (1 Thess 4:17)” (Ibid., 430).
The Easter Vigil proclaims this passage recalling that as Christians, “we have been baptized” (v. 3). The root of the word baptism means “to dip into,” “to plunge,” or “to immerse,” reflects the powerful transformation effected by the sacrament. The last part of v. 3 intensifies the imagery, clarifying that it was a “baptism into his death.” Fitzmyer interprets the phrase as a very bold one, and its background is the early Christian kerygma, embedded in 1 Cor 15:3–5. The death involved in baptism is no mere figurative connection to Christ’s own death. Scripture scholars agree that “Paul means that [the baptized] actually experience a union with him.”487 James Dunn concurs when he writes, “Paul does evidently intend to talk of a real dying of the believer.”488 The thrust of the imagery continues in v. 4 when Paul describes how in baptism, “we have been buried with [Christ].” Fitzmyer contends that “coburial” renders this verse more accurately. He writes, “As a result of the coburial, the Christian lives in union with the risen Christ, a union that finds its term when the Christian will one day ‘be with Christ’…in glory.”489

In v. 4, a tension emerges as baptism’s very real “coburial” with Christ leads to the promise that “we too might live in newness of life.” The baptismal act of unifying death and life stands in contrast to the medical view that sees these human events as mutually exclusive categories. Verse 5 evermore clearly presents the problem as it states, “We have been united with [Christ] in a death like his,” and it ends with the future-oriented statement, “we will certainly be united with him in a resurrection like his.” In question is the degree of self-identification that is possible with Christ’s resurrection.

487 Ibid., 434. Emphasis added.
489 Fitzmyer, Romans, 434. Cf. 8:32; 1 Thess 4:17; Col 2:12.
Dunn most clearly articulates the tension when he describes the Christian as living in a suspended state. Dunn notes that the first phrase is rendered grammatically in the perfect tense, “have been united.” Dunn prefers translating the verb as being “fused” with him! This denotes an act of the past that continues into the present. In other words, “the believer has been and still is bonded together with the effect of Christ’s death, with the same kind of death that he died.” As v. 5 continues, the grammar changes, and Paul employs the future tense pointing to the eschatological dimension of baptism. In other words, baptism is the ritual enactment of faith that then orients the believer toward a future hope. It is thus that Paul later writes, “For in hope we were saved” (Rom 8:24). The difficulty is that the believer lives in a suspended state, “between Christ’s death and Christ’s resurrection, or more precisely between the very likeness of Christ’s death and that of his resurrection, between conversion-initiation which began the process and the resurrection of the body which will complete it. The very real dying of the believer is a life-long process.” Baptism initiates the Christian life when the believer is buried with Christ in the waters of baptism and begins to share in the grace-filled life of Christ, which will one day come to its fullest expression when the believer shares in Christ’s resurrection (vv. 4, 5, 8).

Notice how this scriptural depiction of baptism presents a radical reversal of how most men and women view their own lives as a linear movement from life to death. Certainly this is the operative image in medicine. As examined in the first two chapters,

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490 Dunn insightfully describes this tension as the basis for Christian ethics and conduct (Dunn, “Salvation Proclaimed,” 263).
491 Dunn’s choice of the English word “fused” indicates a strength, if not a permanency of the bond effected in baptism. The same verb reappears in the second part of v. 5, thereby strengthening Paul’s conviction that the baptized will be fused with Christ in a resurrection like his.
493 Ibid.
medicine deploys technology to stave off the progression it sees from birth to death. The abundance of medical devices witnesses to this reality: dialysis machines, mechanical ventilators, heart defibrillators, arterial stents, and more. Palliative care, however, does not fully share medicine’s view that death is the enemy and something to be avoided. It may be easier to forgo some medical devices and technological interventions when one uses the lens of baptism that brings into sharper focus the mystery of how death leads to life. The baptismal identity of a ninety-two year old woman experiencing increased symptoms of dementia, weighing little more than one hundred pounds, and no longer enjoying the comfort of her own home or her life-long hobbies or participating in Mass, may give her surrogates the freedom to discuss and accept DNR orders from her physician.

This passage from Romans articulates the fundamental Christian view that the life of the baptized is a movement from life to death to life. The death in baptism is a real death in the same way as the Eucharist is the real presence of the body and blood of Christ. As the baptized, we can interpret our own impending biological death differently because we have already experienced death sacramentally. The difference is we approach it with confidence in the resurrection. Though arduous and difficult, Christians can approach and experience death without the “sting” (1 Cor 15:56) that this earthly realm normally ascribes to it.\footnote{Ibid., 264.} Admittedly, living in the freedom of baptismal new life is not easy. It is after all, a suspended state between the already and the not yet. Like all suspensions, this one too, is fraught with all the signs of imperfection, instability, and uncertainty that mark everything on this side of eternity. It is not unlike the limbo lived by those who work in palliative care when patients may reasonably vacillate between
nonaggressive therapies or comfort measures and more aggressive curative treatments.

Nevertheless, baptized into the Body of Christ and living in a new mode of life guided by the Spirit of God, we are called to allow our decisions, our motivations, indeed our very lives to be directed by our identity in Christ Jesus.495

**Baptism and Hope in Pope Benedict XVI’s Spe Salvi**

When Pope Benedict XVI issued his encyclical letter on hope, *Spe salvi*, he opened it with a line from Saint Paul to the Romans, “in hope we were saved,” (Rom 8:24). Benedict XVI’s encyclical begins with a spotlight on Saint Paul’s ethical discourse to the Christian community in Rome. In chap. 8, Paul draws upon the new reality for Christians, namely life in the Spirit that has come about because of their baptism into Christ’s death.496 This is the first of several New Testament passages that Benedict XVI highlights to exemplify how Christian hope flows directly from and is intimately connected to the Christian faith.497 More classically stated, faith leads to hope.498

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495 Ibid., 264. See also, Fitzmyer, *Romans*, 438.
496 The consensus among scripture scholars recognizes Rom 6:1–8:39 as a unit (Fitzmyer, *Romans*, 96).
497 Benedict XVI presents an extended reflection on the book of Hebrews. In addition to citing Heb. 10:22–23, he acknowledges the exegetical debates dating back to the Protestant Reformation regarding the translation of the Greek word *hypostasis* in Heb 11:1. See, *Spe salvi*, §2, 7–9. The details of the contested translation are beyond the scope of this present work. See also, Long, *Hebrews*, 175–188. Other examples connecting faith and hope in the New Testament include the letter to the Ephesians where before the community encountered Christ they were “strangers” with “no hope and without God in the world” (2:12). Similarly, Paul urged the Thessalonians not to “grieve as others do who have no hope” (1 Th 4:13).
498 Aquinas distinguishes two differences regarding the order of the theological virtues: the order of generation and the order of perfection. Concerning perfection, charity precedes faith and hope, because charity is the mother, the root, and the form of all the virtues (*Summa theologiae*, I-II, Q. 62, a. 4). In the former, however, “faith precedes hope, and hope charity, as to their acts” (*Summa theologiae*, I-II, Q. 62, a. 4). He reasons that men and women can neither hope for something nor love something if they first do not apprehend it, or rather, know that it exists. Faith pertains to things unseen, and hope is of things not possessed (*Summa theologiae*, I-II, Q. 62, a. 3). As demonstrated in the brief discourse on the interrogative form of the Baptismal creed, Christian faith acknowledges and gives assent to the real existence of God and a heavenly afterlife—things unseen. Christian hope then, is the yearning and longing for the fullness of
Benedict XVI turns to the *Rite of Baptism* to give evidence how the Christian faith today continues to foster life-changing and life-sustaining hope. He draws upon an aspect within the *Rite* whereby the priest asks those to be baptized what it is they ask of the church.\(^499\) The response is “faith.” The priest asks a following question probing exactly what faith gives, and the response is “eternal life.” This liturgical rite ritualizes and makes present for the whole worshipping body the theological claim that faith is the substance, or rather, the grounding foundation, that then gives rise to hope (Heb. 11:1). The pontiff’s reflection echoes the tension discussed above in Rom 6:4–5. Even though in baptism the Christian believer has already died with Christ, the ability to live in that new life promised by the resurrection remains a difficult feat while still living in a context where structures of sin substantially affect daily life. Benedict XVI reflects on this suspended state by questioning whether as humans we really want to live eternally. He writes, “Perhaps many people reject the faith today simply because they do not find the prospect of eternal life attractive…. To continue living forever—endlessly—appears more like a curse than a gift. Death, admittedly, one would wish to postpone for as long

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\(^499\) *Spe salvi* uses the example of infant baptism. Hence, Benedict XVI describes these questions coming before the parents of the infant to be baptized. For the sake of consistency in this current work, I have chosen to continue with the presumption of adult baptism as that is how I began this chapter with citations from the RCIA. The interrogatory questions that Benedict XVI references are found in the Rite of Becoming Catechumens in the first stage of the RCIA (RCIA, in *The Rites*, §75, p. 41).
as possible." He describes the contradiction with these words: “On the one hand, we do not want to die; above all, those who love us do not want us to die. Yet on the other hand, neither do we want to continue living indefinitely, nor was the earth created with that view. So what do we really want?” I pause here in the midst of this rich explanation to point out that this is a question that palliative care professionals are remarkably well adept at asking with gentleness and with an open, non-judgmental spirit. More importantly, most are extraordinarily skilled at not expecting a clear, definitive, and immediate answer. Instead, knowing that these questions and the subsequent decisions will profoundly impact the patient’s life and that of other loved ones, palliative care health professionals, different from most all others, provide patients and their loved ones with the opportunity, the time, and the space to discern the best possible course of action, not necessarily the easiest, the quickest, or the most commonly medically recommended option.

Benedict XVI answers his own question probing what we want with “blessedness,” or rather, happiness. And yet, we really do not know what we want, for when we hope for something, and we get it, we still find ourselves hoping and yearning for more or for something else. Eternal life, Benedict XVI posits, “is intended to give a name to this known ‘unknown’…. ‘Eternal’, in fact, suggests to us the idea of something interminable, and this frightens us.” We may confuse the idea of a life that is eternal by calling to mind the characteristics and things of this life, many of which are burdensome. For example, the surrogate decision makers for the ninety-two year old woman may refute the doctor’s strong recommendation for a DNR because they remember her as a strong

500 _Spe salvi_, §10.
501 Ibid., §11.
502 Ibid., §12.
woman of hope, and they want to remain steadfast in hope for her. Benedict XVI seems to anticipate situations like this when he argues that as Christians, we must keep before ourselves a vision of hope grounded in the scriptures. For example, in the Gospel of John, Jesus assures his disciples saying, “I will see you again, and your hearts will rejoice, and no one will take your joy from you” (John 16:22). Benedict XVI stresses that this is what Christians must keep in mind “if we want to understand the object of Christian hope, to understand what it is that our faith, our being with Christ, leads us to expect.”

To be clear, Christian faith leads us to hope for and expect eternal happiness, or rather, friendship with God. This is the ultimate good. Christian hope leads the believer to pray for other goods, such as for illness to leave our bodies. But Aquinas describes such hope as secondary in relationship to eternal happiness. The believer may hope for a medical breakthrough, but in the tradition, this particular hope for something in the temporal order must be in reference to one’s Christian journey, to one’s vocation to live more fully in the image and likeness of God, and ultimately to one’s baptismal identity that oriented and implanted in the believer the divine promise of eternal happiness.

**Practical Implication for Palliative Care**

If the ultimate good for the baptized is friendship with God, then concretely, this means that the Christian faithful are uniquely positioned to embrace palliative care

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Ibis., §12.

Summa theologiae, II-II, Q. 17, a. 1–2. More fundamentally, Aquinas delineated four characteristics of hope in Part I-II, which include the following: First, the object of hope is something that is good. Second, it pertains to the future. Third, the object of hope must be something arduous and difficult to obtain. Fourth, though difficult to obtain, it must be possible, as hope differs from despair (Summa theologicae, I-II, Q. 40, a. 1).

Summa theologicae, II-II, Q. 17, a. 2. In his reply to objection 3, Aquinas writes, “To him that longs for something great, all lesser things seem small; wherefore to him that hopes for eternal happiness, nothing else appears arduous, as compared with that hope.”
treatments in lieu of aggressive medical therapies in some qualified clinical
circumstances. Because the baptized have already died with Christ, then they can
challenge the prevailing presumption in medicine to treat. For example, when organ
failure sets in, especially in an older person, baptized Christians may first want to
consider palliative care over aggressive interventions. When a disease trajectory clearly
has a downward course and death presents itself as a strong possibility, the Christian
should eagerly consider palliative care. In such a situation, the desired goal of care is not
the deliberate hastening of death, but rather pain management, the treatment of symptoms,
and the avoidance of invasive medical interventions. Likewise, baptized believers may
avoid treatments for a potentially fatal condition when the treatments would likely
prolong pain and suffering. The baptized person experiencing extended unconsciousness
or advanced dementia may elect palliative care over treatments that would more likely
extend life with little or no amelioration to the underlying illness. Lastly, when a
proposed treatment may contribute to a bad death, even if life may be extended, the
baptized ought to more seriously consider palliative care.

Baptism provides a direction for one’s life, an orientation toward eternal
happiness and friendship with God. This reality must have implications for the believer’s
decisions regarding medical treatments. The strength to continue living in one’s
baptismal identity comes from the Eucharist and one’s own prayer. Aquinas aptly

506 Callahan, The Troubled Dream of Life, 200–201. The suggestions that follow come from those
made by Daniel Callahan on challenging the presumption to treat. He adds important qualifications to
these suggestions, such as the necessity of informed consent, considerations regarding familial and social
obligations that patients may have to others, and still-unrealized personal development (Ibid. 203).
Similarly, my reiteration of Callahan’s points herein, presume that in a Catholic context, implementing one
of these scenarios would not be done in such a way as to violate the ERDs, especially those in Part Five,
“Issues in Care for the Seriously Ill and Dying.” Thorough analysis of a particular situation would be
necessary to opine on adherence to the ERDs. In my estimation, none of the suggestions in and of
themselves forthrightly violate the ERDs.
described the Eucharist as the queen of the sacraments.\footnote{Aquinas describes, “Baptism is the beginning of the spiritual life, and the door of the sacraments; whereas the Eucharist is, as it were, the consummation of the spiritual life, and the end of all the sacraments. See, \textit{Summa theologicae}, III, Q. 73, a. 3; See also III, Q. 63, a.6. The Eucharist is the consummation of all the sacraments since it does not move the believer to any other sacramental action.} Still today, the revised rites describe the Eucharist as the culmination of Christian initiation and the Christian life.\footnote{Rite of Christian Initiation for Adults, §368, p. 149.} It is faith in motion drawing together the lives of the gathered people of God into the life of the Triune God and gifting them with hope—hope that heals all the wounds of sin and hope that realigns their desires toward the deepest desire of all, eternal friendship with God.\footnote{Benedict XVI concludes his encyclical by noting that believers can cultivate the virtue of hope through prayer, most especially liturgical prayer. \textit{Spe salvi}, §34.}

### The Eucharist as Sacrament of Healing and Hope

This final section brings the chapter back to where it began—with the breaking of the bread.\footnote{Josef A. Jungmann, S.J.’s seminal work on the early liturgy notes that while today it remains unknown as to exactly what the first eucharistic celebrations looked like and the scope of their shape and form, what is clear is that the oldest sources in the Christian tradition called the celebration “The Breaking of (the) Bread.” This is witnessed in Acts 2:42, 46; 20:7, and elsewhere, most notably in 1 Cor 10:10:16. This reflects that the Eucharist has always been an essential aspect of Christian identity. See, Josef A. Jungmann, \textit{The Early Liturgy: To the Time of Gregory the Great}, trans. Francis A. Brunner (Notre Dame, IN: University of Notre Dame Press, 1959).} The ritual action at the heart of the Emmaus story continues to this day in the Sunday liturgy’s Communion Rite. I will briefly point to three particular components of the Communion Rite within the Liturgy of the Eucharist that show how the Eucharist functions as a sacrament of healing and hope.

#### Agnus Dei

Just before the gathered people of God process to the altar to receive the Body and Blood of Christ, several minor rites packed with theological significance unfold. The
first is the Fractioning Rite. As the priest presider breaks the bread, the rubrics direct the choir or cantor with the congregation to sing the *Agnus Dei*. The invocation, “Lamb of God you take away the sins of the world; have mercy on us,” may be repeated while the presider fractions the consecrated bread and wine into the vessels for distribution to the worshippers. The congregation’s prayer affirms and reminds them that this—the broken, dead, risen and living Lord Jesus in all his humanity and divinity—is what takes away the world’s sin. One of sin’s many effects in our human lives is debility and disease. Asking Jesus Christ to “have mercy on us” is another way of asking that he heal us. The conclusion to this repeated mantra during the fractioning rite is of importance. The final trope ends with the words *dona nobis pacem*, grant us peace. As the gathered faithful—themselves a living presence of the Body of Christ—prepare to receive the sacramental Body and Blood of Christ, we pray that his presence in the consecrated bread and wine will give us peace.

This has implications for those bearing the burdens of illness and disease, most especially those with chronic and terminal illnesses who know their conditions will never improve. It also carries great meaning for the many loved ones and family members who journey with one who suffers from such illnesses. The unsettling and destabilizing nature of human illness is met by the possibility of divine peace that is offered in the breaking of the bread. This stands in contrast to the tacit hope that medical responses, therapies, and devices will lead to a permanent and lasting peace. Understandably, the search for drugs, therapies, and medical protocols is to some degree, a search for peace in the midst of the chaos imposed by the disease. We want medicine and any other available modern techniques to bring about some sense of containment to the spreading cancer, the

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advancing dementia, and the progressing neurological disfigurement. Thereby, it may give us some peace. But here, before the real presence of Christ, we acknowledge our need for this One whose mercy for us can “grant us peace.”

“Behold the Lamb of God”

A second preparatory ritual prior to receiving the Body and Blood of Christ entails the priest taking the host and chalice into hands and saying, “Behold the Lamb of God, behold him who takes away the sins of the world. Blessed are those called to the supper of the Lamb.” Together with the presider the gathered worshippers respond, “Lord, I am not worthy that you should enter under my roof, but only say the word and my soul shall be healed.” This short phrase weaves together faith, hope, and healing. The assembly’s response echoes a passage from the gospels of Matthew (8:8) and Luke (7:6–7) where a Roman centurion asks Jesus to heal his servant. In both gospels, Jesus himself identifies the centurion’s request as an act of faith (Matt 8:10; Luke 7:9). Faith emerges as the central motif of the passage. It is neither primarily a miracle-story nor a story about the worthiness of this particular Gentile. The centurion approaches Jesus with faith—with some conviction or knowledge that Jesus is able to bring about mighty

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512 Roman Missal, The Order of Mass, §132, p. 653. Of note, between the Agnus Dei and this final prayer preceding the communion procession, the General Instruction of the Roman Missal (GIRM) directs the priest and the faithful to prepare to receive Christ’s Body and Blood (GIRM, §84). The Roman Missal offers two prayer options for the priest himself to pray quietly, the second of which ends with a prayer for healing (§131). Paul Turner’s describes the priest’s prayer as one for health, a debatable interpretation. He notes that the rubrics direct the faithful to prepare themselves in a similar way. See, Paul Turner, Let Us Pray: A Guide to the Rubrics of Sunday Mass (Collegeville, MN: Liturgical Press, 2006) 131–132.

513 Roman Missal, The Order of Mass, §132, p. 653. Modern science has challenged the dualistic account of two discrete substances of body and soul. An alternative account posits that the activities traditionally ascribed to the soul can be described and verified as brain processes. Scholars name this reductive physicalism. Christian philosopher Nancey Murphy uses biblical scholarship as well as contemporary scientific findings, especially neuroscience, to argue for a non-reductive “physicalist” idea of the soul in the sense that it is more of an inner self that pertains very directly to the body. Healing the soul has implications for healing the body. Nancey C. Murphy, Bodies and Souls, Or Spirited Bodies? (New York: Cambridge University Press, 2006).

deeds or miracles. Bound also to this faith conviction, the centurion comes with an implicit hope, a hope that this real encounter with the living Lord will in fact bring about healing. In other words, the centurion, a Gentile, hopes that the future dynamics and relationships of his household will be changed and made for the better because of this encounter with Jesus the Lord.

The Church’s liturgy places this very prayer of the centurion onto our lips just before we say “Amen” to the Body and Blood of Christ presented to us. We ask the Lord of life to come into the intimate depths of our own home, our lives, and to enact within us the divine healing that will grant us peace. This is what I have in mind when I see the man with unmistakable scars across his shaved head slowly limping his way toward the minister of most holy communion, or the parent assisting her pre-adolescent child in leg braces, or the couple I know to be struggling with depression, and bipolar disorder.

“Lord, only say the word and my soul—and their soul—shall be healed.”

Prayer After Communion – Eucharist as Hope

Lastly, healing and hope permeate the texts of the Prayer After Communion that concludes the Communion Rite. Joseph Dougherty observes, “in keeping with their petitional nature, the prayers after Communion consistently beg for greater faith, hope, and love in multitudinous ways.” The prayers concluding the Communion Rite frequently ask God to gift us with the theological virtues. Often, hope is at their core, and true to its deepest character, the hope imaged in the prayers is eschatological. For example, Palm Sunday’s Prayer After Communion beseeches the Lord “that, just as

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through the death of your Son you have brought us to hope for what we believe, so that by his Resurrection you may lead us to where you call.\textsuperscript{516} Easter Sunday for example, prays that “renewed by the paschal mysteries, [we] may come to the glory of the resurrection.”\textsuperscript{517} Concluding the Solemnity of the Ascension, the prayer petitions “that Christian hope may draw us onward to where our nature is united with you.”\textsuperscript{518} A final example from the Thirteenth Sunday in Ordinary Time prays “that, bound to you [O Lord,] in lasting charity, we may bear fruit that lasts for ever.”\textsuperscript{519} These prayers look forward to the fulfillment of God’s promises and propel the people of God to live more fully in faith, hope, and love. Admittedly, this is not a comprehensive or statistically sufficient sample size. These few offerings, however, tell the worshipping body something very important about the liturgy’s own eucharistic theology and the intention of the liturgy to deeply affect the direction and orientation of our lives.

The Eucharist sustains us as the baptized people of God, nourishing and strengthening us in our baptismal identity as we continue living in the suspension of already sharing in the death of Christ and the not yet fully sharing in the glory of his resurrection. It is the regular, weekly, and even daily bread gifted from heaven and meant to stir our faithfulness and keep our hearts and minds set on the hope of the glories of life everlasting yet to come.

My intent has been to simply raise a few, yet poignant aspects of the eucharistic liturgy to demonstrate how it enables healing. I have described how the Communion Rite begins with pleas for peace and healing that the real presence of Christ in consecrated

\textsuperscript{516} Roman Missal, §26, p. 270.
\textsuperscript{517} Ibid., §76, p. 375.
\textsuperscript{518} Ibid., p. 419.
\textsuperscript{519} Ibid., p. 457.
bread and wine can provide, and it ends with prayers for hope, characterized by their assurances of heaven and the things that last forever. I ended with brief attention given to the Prayer After Communion, which petitions God to transform us evermore in faith, hope, and love, through the reception of the consecrated Body and Blood of Christ. The beauty of the text in these prayers serves as a final punctuation to the sacramental-liturgical rites.

**The Humanity of the Sacraments**

If there is any validity in Chauvet’s sacramental theology, then these sacramental rituals leave open the question of how they affect us, the worshipping body. How might these prayers, and the larger context of the rituals in which they appear, impact a family living with a loved one who suffers with chronic illness? How might a prayer after communion affect the healing, or rather a renegotiated meaning, in the midst of a devastating illness for a mother in her final weeks of life suffering with terminal breast cancer when the prayers asks the Lord to “abide graciously…with your people, who have touched the sacred mysteries, that no dangers may bring affliction on those who trust in you”? Or, the oration which pleads, “Accompany with constant protection, O Lord, those you renew with these heavenly gifts and, in your never-failing care for them, make them worthy of eternal redemption.”

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520 Prayer After Communion for the Saturday After Ash Wednesday, *Roman Missal*, p. 201.

While a more comprehensive analysis of this and other prayers after communion is needed, I want to draw attention to three primary images in this particular prayer. First, it asks the Lord to renew those who have just celebrated and received the Eucharist. Presumably, the renewal, most fundamentally speaking, is a renewal of their baptismal identity in the dead and risen Christ Jesus. Second, the heavenly gifts to which it refers, may reasonably include the theological virtues—supernatural gifts which God alone can give. Third,
church—all of the church and all of its ministries, including its healthcare ministries—to reach deeply into the fears and vulnerabilities of its peoples’ sufferings, to abide with them, to accompany them in their ever deepening experience of dying with Christ and awaiting in hope for fuller experiences of rising with him to newness of life.

I will grant that it is difficult, indeed very difficult for members of the worshipping body to envision how these sacramental celebrations may serve to profoundly shape their own experience of illness and death, especially when many presiders of the liturgical rites only half-heartedly attempt to communicate the depth of the prayer. Priests receive little if any training or awareness of what it might take for them as leaders of prayer to communicate the inner essence, the urgency, and the beauty of the prayers to the lives of the worshipping body. It is not helped by the fact that most Catholics only experience baptism as a semi-private affair that takes place isolated from the wider community of faith on a Sunday afternoon. Further complicating the vision articulated in this chapter is the reality that most baptisms occur by dribbling a scintilla of water over the individual’s forehead—all but obscuring the dangerously provocative image of baptism as immersion in water to the point of death. Yet poor pastoral and liturgical practices do not nullify the richest and most profound aspects of our Christian tradition. Rather, the depths of the tradition call us and challenge us to evermore fully embody in ritual worship and in the ordinariness of our lives the words we profess, the poetry we pray, and the creeds we believe.

It bears recalling that the sacramental-liturgical life of the church, as a focal practice, needs to be repeated and revisited time and again. We return to it time and

it ends by stirring the communicants’ very hope for eternal redemption, or rather, being saved from death to enjoy eternal friendship with God.
again because we need to hear the scriptures afresh and the prayers that explore the many layers of the paschal mystery all throughout the liturgical year in which the mystery gradually unfolds. And we need to return to our own practices in these rituals because our lives change. Our need for healing and hope is always evolving, waxing and waning, depending upon our own life circumstances. Morrill argues, “the specific content of this paschal mystery needs to be repeatedly expounded through word and sacrament lest we lose sight of what God we are worshipping: the God who is for humanity, for the happiness and peace of all people; the God who is known in those who join in that activity; the God whose images are not sought in static objects but in action.” It is this God who gives people hope, just as it did for Cleopas and his companion. The repetition of this divine hope and sacramental healing stand to help those engaged in palliative care, primarily patients and providers. It can help them to gradually see the limitations of the promises made by medicine and technology. The sacraments, as the saving-healing actions of God, offer us a healing that is different and yet so needed. An extended quote by Morrill serves well to help summarize the central role of baptism and Eucharist as sacraments of healing. He writes:

The church’s central liturgical action is at the font and the table, baptism and Eucharist, and both of these in conjunction with the proclaimed word…. Only by them can one make sense of what we do as a church, as well as what our hope is as a church in the face of death. Our not skirting the margins, allowing our faith to face the harsh reality of human death…allows us to enter into them and be consoled—if not in the moment then over time—in the paradox of the paschal mystery. For if we recover this belief in God’s love for all creation unto death, recover it in a way that is practical for lives of faith, then we recover as well the patristic wisdom that the glory of God is the sanctification and salvation of people. God’s graciousness answers the greatest of human need. God’s powerful love is known in humans’ living response to that grace. The paradox emerges in God’s keeping of time, which is not ours, while the glory resides in an ethics, a way of

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life, practiced in eschatological hope that, in most sound tradition, characterize the entire Christian life, including death, as the worship of God.  

Dame Saunders explicitly viewed the founding of St. Christopher’s Hospice as an extension of the worship of God. As explained in the opening chapter, the women religious who founded the Catholic healthcare ministries all across the United States also saw their committed loving accompaniment of the sick and dying as something intimately connected to another commitment to a life of prayer. Today, we need leaders in healthcare ministries, doctors and nurses and other healthcare professionals practicing in palliative care, to allow the deepest, the most beautiful convictions of their faith traditions to speak prophetically and profoundly to their medical art and skill and to the administrative strategic planning that is necessary to allow for the fullness of this type of care possible. This is especially so for Christian men and women who participate in a liturgical tradition founded upon the paschal mystery. The Eucharist we celebrate is intended to take effect in our lives. Like the disciples who recognized the Lord in Emmaus during the breaking of the bread, our lives too, are to be changed by these sacred mysteries. Thus, it is not only healthcare professionals who can be the agents for change in society’s experience with medicine, but patients themselves, their loved ones and family members. Together, all who participate in the eucharistic liturgies can further the experience of palliative care and preserve the sacramental religious dimensions of its origins.

Summary

523 Ibid., 249.
This chapter began with a review of twentieth-century sacramental theology that envisioned the sacraments as graced encounters with the living presence of Christ in the Spirit. A close examination of Louie-Marie Chauvet’s systematic sacramental theology elucidated how the sacraments function symbolically through gift-exchange, which differs from the economic exchange and technologically-saturated characteristics that dominate much of society. I argued that the sacramental-liturgical life of the church could further the work and practice of palliative care because they share the perspective that medicine and technology have limits, and alone they cannot heal people with chronic and terminal illnesses. Moreover, they share a common goal of bringing about healing that differs from curing.

I have argued that baptism and Eucharist provide the foundations for the healing that flows from the sacramental-liturgical life of the church because both orient the believer toward an eschatological hope. This aspect of the sacramental-liturgical life fosters healing by relocating the hope of Christian believers away from a hope hijacked by the technological paradigm that is ubiquitously available in the medical milieu, and instead, grounds that hope in Christ’s victory over death witnessed in his resurrection and leading to eternal happiness with God. By spotlighting key moments in both the Rite of Baptism and in the Liturgy of the Eucharist, most specifically the Communion Rite itself, I have tried to draw attention to the concrete ways the sacraments form the worshipping believer to evermore embody a life like that of the disciples leaving Emmaus and returning to Jerusalem, and a life like that of the dead, risen, and living Christ Jesus.

The sacraments are gifts from God that reveal to us as believers the depth of God’s love for us. They point us toward the horizon of eschatological hope and the
things that last forever. That which lasts forever is love. Faith opens us to realities of heaven and life everlasting. Hope stirs our yearnings to one day come enjoy the glories and happiness of eternity, and love is what lasts forever once the glories of heaven are attained. Faith and hope dissolve away, and love remains eternally. Faith and hope arise from caritas, or love. This is true in the Christian tradition, and it was a compelling component of Dame Saunders’ own story and vision. Thus, the final chapter focuses on love.
Chapter 4 – Love:
The Essence of Palliative Care

The love of Christ urges us on. (2 Cor 5:14)

Love – The Ground of the Modern Palliative Care and Hospice

At the onset of this work I contrasted the depiction of the religious aspect of palliative care from two physician writers, Jeffrey Bishop and Joseph Fins. Like most medical histories, Fins recounts Dame Cicely Saunders’ desire to treat the intractable suffering of cancer patients.\(^{524}\) Also in the opening chapter I recounted Saunders’ experience of caring for David Tasma in the last month of this life. There remains one crucial detail not often told. Though the medical histories remain silent, Saunders’ biographer does not. As Dame Saunders cared for David she fell in love with him. David’s deep isolation from family, culture, and homeland, weighed heavily on Saunders. Through the course of their encounters, “it was overwhelmingly borne in on Cicely how acute the need was, how dreadful the despair of so many people. Gradually an idea began to take shape, that perhaps she, Cicely Saunders, could do something about it…. [B]eing so close to someone who was dying showed her the need for a rounded care for the terminally ill that was totally lacking….\(^{525}\) Before dying, David shared with the ward sister that he had made peace with God. He left what little he had to Cicely saying, “I’ll be a window in your home.”\(^{526}\) Saunders knew she had to do something for the many people dying lonely, painfully agonizing deaths. A moving and personal love launched the dream for the St. Christopher’s Hospice house. David’s death and her deep

\(^{524}\) See Fins, *A Palliative Ethic of Care*, 16.

\(^{525}\) Du Boulay, *Cicely Saunders*, 36.

\(^{526}\) Ibid.
love for him crystalized for Saunders that she must build not a hospital but a home for the ill and dying.

More than twelve years later as Dame Saunders worked at St. Joseph’s Hospice in her early years as a physician, she made plans to realize her dream of building St. Christopher’s. Then one day she met Antoni Michniewicz, another Pole, and love struck again. Antoni was a devout Catholic and widower. For one month in the summer of 1960, Saunders’s personal journal revealed her love for Antoni, the prayers she wrote to God for peace, and the help she needed to prudently remain his physician. Shirley DuBoulay describes Saunders’ overwhelming grief that flooded her heart when Antoni died, yet it came with gratitude, “gratitude that she had loved and been loved.” This deep human experience of love was interwoven with an awareness of Divine love. Du Boulay writes:

She seemed to love God more because they had loved each other and one love had dissolved into the other; she related in a new way to all who suffer…and of course she identified especially with the bereaved. ‘Because I belonged to him as never to anyone before so I belong to others – and to life itself more deeply. He gave me a way to others – to those who walk through bereavement and to others too – but I have learned to use it and be ready to be involved and to try and understand them.’

Saunders’ biographer describes how David provided the vision for St. Christopher’s, and Antoni ignited the drive to realize it. Saunders’ experiences of love would permeate what academic medicine identifies as the first modern hospice house. Saunders wrote in her journal, “I have shared this grief and know that there is something stronger behind it all – not an answer, no explanation, but a presence. We believe, many of us here, that this is the presence of God who has shared our suffering with no more than the equipment of a

\[527\] Ibid., 85.
\[528\] Ibid., 85–86.
man and who, having come through, shares the sorrows of all…and will transform them.” For Saunders, the experience of intoxicating human love drew her to contemplate God’s love for all men and women. It propelled her to more fervently work towards establishing St. Christopher’s hospice as a communal home filled with love and joy for the frail elderly, the chronically sick, and the dying.

I want to draw attention to two overarching characteristics of Dame Saunders’ experiences of love. The first entails the individual, the love and the care that she experienced in these two particular experiences with David and Antoni. The second involves the move she instinctively made from the individual to the institutional or the communal. From these amorous experiences, Saunders felt compelled to radically change the experience of living with chronic and terminal illnesses not solely for these two men, but for many others. In other words, these personal experiences of love spilled over into a creative love that drove Saunders to desire for others a similar experience of being held in love while experiencing frailty, chronic conditions, and terminal illness. And, it can be said she succeeded! Institutional change came about from the complexly rich layers of love.

These two aspects of love, the individual and the institutional, are the focus of this chapter. It is divided into two sections. In the first, I will explore the individual dimension of palliative care and recount how Benedict XVI described it as “loving care” as well as a human right. Then, I will consider love as the motivator for political and systemic change. I continue relying considerably on the writings of the Pope Emeritus for the first section of the chapter. His two encyclicals on caritas provide important insights that uniquely illuminate the understanding of palliative care as loving care. By

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529 Ibid., 86.
examining these encyclicals it becomes clear how love not only motivates personal relationships but also has the capacity to effect broader systemic change and benefit the common good. In Part II, I conclude the chapter with the eucharistic image and liturgical enactment from the Gospel of John by examining the Holy Thursday liturgy, specifically the footwashing ritual. This liturgical embodiment of John’s Last Supper portrays love with both individual and communal dimensions. It dramatically reveals the paschal mystery as it foreshadows Jesus’ death without diminishing the motif of glory that marks this part of John’s gospel. It ends with Jesus’ mandate to go into the world to serve and love one another. Thus, the Johannine footwashing provides importantly rich imagery for palliative care.

**Part I: Love and Palliative Care**

**Palliative Care As Individual Loving Care**

Dame Saunders’ experiences of love find resonances in the writings and speeches of Benedict XVI. The current Pope Emeritus gave remarks about palliative care in 2006–2007. In three separate addresses, he described it as “loving care.” Moreover, he named it a fundamental right that belongs to every man and woman.

In preparation for the fifteenth World Day of the Sick, Benedict XVI made his first reference to palliative care. He declared it “a right belonging to every human being, one which we must all be committed to defend.”

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right because he understands it as “loving care” offered by both healthcare practitioners and family members. The pontiff encourages a “particular concern for the infirm,” in imitation of the Good Samaritan (Luke 10:25–37). He expressed an understanding of palliative care that resembled the holistic care offered by Dame Saunders. He emphasized the need for spiritual accompaniment alongside the physical assistance for the sick. For both the pontiff and Saunders, palliative care involves more than what the medical discipline provides.

Benedict XVI advanced his argument for palliative care in a second address in 2007. This speech alludes to a community engaging in loving care for the ill and dying, something beyond the confines of the professional medical community and broader than clinical social work, clinical psychology, and board-certified chaplaincy. Although those disciplines are important and bring gifts to the operations of contemporary healthcare, the pontiff contends, “Many other people need to be prepared or encouraged in their willingness to spare neither time nor expense in loving care for the gravely ill and dying.” It is important to note the pontiff’s awareness that the sharing of time can play an indispensable role in caring for those who are sick. This stands in tension with the efficiency that governs the operations of medical services, and it forms his argument favoring palliative care over that of “actively assisted death.”

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531 Ibid.
533 Ibid.
534 Ibid.
In his third treatment of palliative care, Benedict XVI addressed the participants in the 22nd International Congress of the Pontifical Council for Health Pastoral Care. At that event he emphasized the need to balance aggressive medical interventions with other forms of loving care, especially an attentiveness to the spiritual dimension, as well as the integral role of the community. He said:

Indeed, recourse to the use of palliative care when necessary is correct, which, even though it cannot heal, can relieve the pain caused by illness. Alongside the indispensable clinical treatment, however, it is always necessary to show a concrete capacity to love, because the sick need understanding, comfort and constant encouragement and accompaniment. The elderly in particular must be helped to travel in a mindful and human way on the last stretch of earthly existence in order to prepare serenely for death, which – we Christians know – is a passage toward the embrace of the Heavenly Father, full of tenderness and mercy.  

The pontiff envisions care that is directed toward the physical, symptomatic needs of the patient, as well as care tending to the spiritual, and even the eschatological dimension of the human person. Here again, connections emerge with the care that Dame Saunders offered. As she cared for David and Antoni, her encounters with them included conversations about an existence after death. She neither forced these conversations nor ignored them. Rather, the trusting relationship enabled a safe environment to explore how they understood the final stretch of their earthly existence and the possibility of something beyond.

Lastly, I want to note how Benedict XVI envisions loving care as a responsibility of the entire community. It is not the work of just one individual or discipline. He states:

I would like to add that this necessary pastoral solicitude for the aged sick cannot fail to involve families, too. Generally, it is best to do what is possible so that the

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families themselves accept them and assume the duty with thankful affection, so that the aged sick can pass the final period of their life in their home and prepare for death in a warm family environment. Even when it would become necessary to be admitted to a health-care structure, it is important that the patient's bonds with his loved ones and with his own environment are not broken. In the most difficult moments of sickness, sustained by pastoral care, the patient is to be encouraged to find the strength to face his hard trial in prayer and with the comfort of the sacraments. He is to be surrounded by brethren in the faith who are ready to listen and to share his sentiments. Truly, this is the true objective of “pastoral” care for the aged, especially when they are sick, and more so if gravely sick.

The pope advocates for the dying to spend their final weeks and months in their home where they can prepare for death in the comfort of a familiar environment. The family and even the parish community must faithfully preserve and foster their relationships with the ill and dying. The patient and her family need the support of the community of faith. The community created in a long-term care facility or nursing home cannot be presumed to suffice.

From the perspective articulated by Benedict XVI, the community of faith bears a responsibility to the sick and dying. By highlighting the role of the community, the pope points out the limits of medicine in supporting the incurably ill. Perhaps more than the other medical specialties, palliative care practitioners recognize the benefits of a community as they actively involve resources from nursing, social work, and pastoral care unlike any other discipline in medicine. But long before the advent of medical specialty teams, loving care marked the earliest Christian communities. It is central to Christian identity. They extended care, respite, and love to the weary and the dying for no other reason other than they saw Christ’s image and likeness embedded within every human person. They tended to the sick and picked up the dying, giving them hospitality and loving care. These were actions that changed the course of Western medicine.

536 Ibid.
Benedict XVI emphasizes that this characteristic of the Christian community must not fade with time. Such loving actions ought to be the marks of Christians today. The pope calls physicians and healthcare professionals who daily work with the incurably and terminally ill, along with the patient’s family, to provide loving care. He writes:

Here I would like to encourage the efforts of those who work daily to ensure that the incurably and terminally ill, together with their families, receive adequate and loving care. The Church, following the example of the Good Samaritan, has always shown particular concern for the infirm...[and] continues to stand alongside the suffering and to attend the dying, striving to preserve their dignity at these significant moments of human existence.  

He envisions this loving care overflowing from a community—ultimately the people of God—offering their gifts to the service of the sick.

These instances when Benedict XVI reflected on the topic of palliative care offers two important points. First, he recognizes that in the past several years, palliative care has become a legitimate and distinctive method of medical practice in caring for the elderly and dying. Second, through these remarks, he has unleashed it from the tether of euthanasia and physician-assisted dying that some Catholic theologians have accused it of masking. 

He began his remarks on palliative care by naming it as a human right, and then he reinforced the idea that it ought to entail loving care.

Benedict XVI’s phrase, loving care, I believe, stands as part of the wisdom of the Church and a new and important contribution to the conversation. It serves to transform the overly-technical nature of healthcare. Within the walls of healthcare institutions, one hears repeatedly about quality care, respite care, compassionate care, or comfort care.

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537 Pope Benedict XVI, World Day of the Sick.
538 The association of palliative care with euthanasia and physician assisted death in the Catholic tradition can be found in Pope John Paul II’s encyclical *Evangelium Vitae*, §88 and in the *Catechism of the Catholic Church*. In the latter euthanasia appears as a heading followed by four paragraphs from 2276 to 2279. Paragraph 2279 encourages palliative care as a “special form of disinterested charity.” See also, Ron Hamel, “Palliative Care—Stealth Euthanasia?” *Health Progress*, 95 no. 1 (Jan.–Feb. 2014), 68–71.
These terms offered by the medical community are important, and yet they suffer from the same sterility that makes the intensive care unit an undesirable place to die. Our deepest selves do not long for quality. We yearn for understanding, for hope, and ultimately for love. This is why Benedict XVI encourages Christian communities to be witnesses of the Lord’s tenderness and mercy for the world’s incurably ill. Like the Good Samaritan, he envisions the Church showing a particular concern for the infirm to lift up and preserve their dignity at this most significant moment of their life.539

Benedict XVI’s image of loving care may best be understood against the backdrop of his first encyclical on love, Deus caritas est. An analysis of its key points will help explain how to reconcile an understanding of Dame Saunders’ erotic relationships with loving care. Furthermore, Deus caritas est will bridge the transition into the discussion of how love can be the catalyst for systemic change.

Love – Ecstatic Eros and Agape

It is tempting to think that Benedict XVI’s vision for loving care is an inspiring image that validates caregivers and gives them a warm fuzzy feeling. That is hardly the case. By employing the term loving care, our attention drawn to the root of the first term—“love.” It is a simple word, and yet, Benedict intends to use it with all its complex richness. We can make this assumption because he articulated multiple variations for the term in Deus caritas est, which predated his comments on palliative care. There, he explained an inner unity in love understood both as eros and agape. What I am saying is that a deeper exploration into the Christian tradition’s densely textured understanding of

539 Benedict XVI, World Day of Sick.
love can elucidate how Saunders’ experience of falling in love with David and Antoni impacted her passion to engage in systemic change of healthcare practices for the vulnerably ill and dying. To show that Benedict XVI is not alone in his view on love, I draw from the work of Sarah Coakley. Like the pontiff, this Anglican theologian argues for a unified cohesion between human erotic desire and divine love.\textsuperscript{540}

Coakley’s venture into creating a \emph{theologie totale} aims at transcending “false divides” plaguing theological discourse and society. At the crux of her work stands a prayerful contemplation of the Trinity from which Coakley engages spiritual, ascetical, sexual, and social considerations. One of the divides most troubling to her and pertinent to this present work, is the sharp separation between \textit{eros} and \textit{agape}.

In the early twentieth century Anders Nygren reawakened this theological debate.\textsuperscript{541} He viewed \textit{eros} primarily as self-love and pertaining to humans. This he contrasted with \textit{agape}, which is love flowing from God, completely selfless and thus, fundamentally foreign to men and women. The characteristically heinous \textit{eros}, for Nygren, remains irreconcilable with \textit{agape}.

Among the varied responses to Nygren, M.C. D’Arcy countered that “no sharp divisions can be made at any one moment of their history between the two loves. It is always, we must remember, a full human person who is loving, and in that love, there are

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\item[540] The opening of \textit{Deus caritas est} presents the interconnected nature of \textit{eros} and \textit{agape}. Benedict XVI provides a compelling Christian interpretation of \textit{eros} that refutes perceptions that Christianity opposes erotic love and its divine overtones. He notes how the Greeks considered it a type of intoxication from divine powers. To ascend to this ecstasy, \textit{eros} needs purification, renunciation, growth, or healing. \textit{Eros}, united to \textit{agape}, ascends to the Divine. \textit{Agape} expresses a loving concern and care for the other. For Benedict XVI, it is the free gift of love that God offers. As such, it can be characterized as a descending love that balances the ascendant character of \textit{eros}. \textit{Eros} is love received whereas \textit{agape} is love given. Ultimately, Benedict XVI argues that the two “can never be completely separated” (\textit{Deus caritas est}, §3–15).
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sure to be many different strands."542 He faults Nygren for "forc[ing] them both into such contrasting shapes that neither is alive."543 For D’Arcy, men and women have one love with two poles: active and passive, taking and receiving, self-regarding and self-surrendering, masculine and feminine. He concludes, “the secret of the two loves is, therefore…to be found in persons and in the relation of persons.”544 This English Jesuit helped to liberate erotic human love and argued for its grounding in agape itself. Although Christian thinkers throughout the twentieth century rallied in support the scriptural primacy of agapic love, there nevertheless remains variation in what this means and what it looks like.545

Coakley grounds her twenty-first century engagement of eros and agape in the right ordering of desire.546 She starts with the “Fathers” noting how “for them, the perception of ‘perfect relation in God’ (the Trinity) was fundamentally attuned, and correlated, to their concomitant views about men and women, gender roles, and the nature of ‘erotic’ desire.”547 Just as D’Arcy rejected Nygren’s bright line between eros and agape, Coakley rejects a dichotomous distinction between God and sex. She sees a deep harmony between the two for they have a shared root—desire. There is an irrevocable, albeit “‘messy entanglement’ of sexual desire and desire for God.”548 The latter is always primary because “desire is an ontological category belonging primarily to

543 Ibid., 80.
544 Ibid., 363. He buttresses his conclusion with thoroughgoing scrutiny from other thinkers insisting the same, such as Burnaby, Descoqs, Buber, Scheler, and Hunter Guthrie.
545 Gene Outka’s analysis and synthesis of more than a dozen writers on agape demonstrates the wide variation. He gives special attention given to D’Arcy, Gilleman, Kierkegaard, Niebuhr, Nygren, Ramsey, and Barth. See, Gene Outka, Agape: An Ethical Analysis (New Haven, CT: Yale University Press, 1972).
547 Ibid.
548 Ibid., 155.
The desire that God has for all of creation to participate in the divine, trinitarian life remains the grounding root for all other desire, including sexual desire. Coakley draws from patristic sources, most importantly, from Dionysius who posited an equivalence between “yearning” (eros) and love (agape). Coakley admits no quick route between the two terms and adds that purgation is required, but “the important point is that the protoerotic dimension for him is divine.” The Spirit, divine Wisdom, comes to the aid of men and women, moving them to divine yearning. The key of divine yearning is ekstasis, which Dionysius preeminently attributes to God. The patristic writer points out how God moves beyond himself and outside of God’s own transcendent dwelling in loving care towards God’s own creation. And yet, in this outpouring of loving care and intimate closeness, God nevertheless, remains within himself.

Coakley’s venture into Dionysius’ writings retrieves this important notion of ekstasis, which sheds light on the love that Dame Saunders experienced with David and Antoni. Coakley sees how ekstasis “allows for an implicit acknowledgment of love across difference; for it reflects on the moment of divine love across an ontological divide. Dionysius, in fact, says that the ecstatic dimension of love can operate whether or not the parties are equal.” Now we can begin to see how a physician could love her patient and how the patient could love her in return. They encountered a divinely inspired love,

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549 Ibid., 10. This is part of the author’s exorcism of the Freudian influences on a contemporary understanding of desire. She turns Freud on his head. It is not that God language is really talk about sex, and that sex is really about God (Ibid., 316). Coakley counters, “It is not that physical ‘sex’ is basic and ‘God’ ephemeral; rather it is God who is basic, and ‘desire’ the precious clue that ever tugs at the heart, reminding the human soul – however dimly – of its created source. Hence… desire is more fundamental than ‘sex’…. [I]n God, ‘desire’ of course signifies no lack – as it manifestly does in humans. Rather, it connotes that plenitude of longing love that God has for God’s own creation and for its full and ecstatic participation in the divine, trinitarian, life” (Ibid., 10).

550 Ibid., 10, 51–52.
551 Ibid., 313.
552 Ibid.
553 Ibid., 313–314.
554 Ibid., 317.
drawn together by the Spirit. Coakley sees how in a divinely rooted love, the Spirit may “interrupt” a “merely ‘egological’ duality” in a relationship. By becoming aware of “a necessary ‘third’,” as Saunders did with both David and Antoni, the two preserve their own inherent integrity while also experiencing an ecstatic exchange and attention to the other.

Similar to Coakley, when Bernard Häring reflected on the church’s mission in healthcare, he envisioned a redeemed and redeeming love that mobilizes “our deepest healing powers.” For Häring, redeemed love moves beyond egocentrism. It comes from and leads to God. Where Coakley posits a Spirit-centric vision of love, Häring points to Jesus as the source and model of redeemed love. Thus, “redeemed and redeeming-healing love is a most precious fruit of faith. Jesus healed people, above all, through his love.” Like Jesus’ love, this healing power affects personal relationships, and it affects the civic community.

Dame Saunders experienced a love with David and Antoni, intertwined with elements of *eros* and *agape*. Perhaps her ability to experience erotic love with these two, and yet not become entrapped by it, was due to the loving care she observed and learned from the Irish Sisters of Charity at St. Joseph. Her experience of working with a community of Christian women who dedicated their lives to a Christ-like love may have given her the model she needed to transcend the inwardly directed *eros* love and moved

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555 Ibid., 318.
556 Häring, *In Pursuit of Wholeness*, 74. For a broader consideration of the author’s perspective on love, see, Bernard Häring, *The Law of Christ*, 83–107. Like Coakley, Häring describes love as participation in the triune love of God. He also notes that it must penetrate nature to subsume it and exalt it (Ibid., 92).
557 Ibid., *In Pursuit of Wholeness*, 74.
558 Ibid., 75.
toward the other-centered, outwardly focused love of agape. The love she gave and received at an individual level led her to create an institution grounded in and guided by love. Put differently, Saunders experienced ecstatic love. When Benedict XVI spoke of palliative care as loving care he indicated that such care needs to move beyond medical care. Envisioning palliative care as loving care means that palliative care practitioners ought to seek the living presence of the Divine, the Spirit, and allow it to draw them into an ecstatic experience with the patient—to allow them to move outside of themselves, to relinquish the security of their clinical knowledge and scientific matrices, so that their care for the patient may reflect a glimmer of God’s luxuriously loving care for creation. Just as God remains fully Godself in the midst of God’s act of ekstasis, healthcare practitioners can retain their professional roles while also allowing the Spirit to “interrupt” the sterility of professional-patient relationship to imbue it with loving care. This means that palliative care practitioners must have a stake in the lives of their patients. This is not to say that they must fall in love with them, but they ought to look for heartfelt human connection. They ought to share a yearning with their patients and have the freedom as Saunders did to express it.

Love – the Impetus for Systemic Change

When Benedict XVI spoke of palliative care in the addresses in 2006–2007, he voiced a keen awareness of the necessity of structural change that must occur in order for palliative and loving care to flourish. He urged the Church to call for just social policies that work to eliminate the root causes of many diseases and policies that improve the care

559 Different from women religious, Saunders was married. I do not want to perpetuate the view that the only or the best models for a balanced and transcended erotic love are celibates.
for the dying. Policies should “create conditions where human beings can bear even incurable illness and death in a dignified manner. Here it is necessary to stress once again the need for more palliative care centres which provide integral care, offering the sick the human assistance and spiritual accompaniment they need.”

Central to his call for loving care is humane, Christian accompaniment with the sick and dying. For this to occur, he pushes for the systemic reforms. He urges, “if humane accompaniment on the journey towards death is to prevail, structural reforms would be needed in every area of the social and healthcare system, as well as organized structures of palliative care... [T]he hospice movement has done wonders. The totality of these tasks, however, cannot be delegated to it alone.”

The second half of Deus caritas est portrays what love enacted in society can look like for the church’s members and the institutions they create. Insofar as it is a service of the church, love must attend to human suffering and material needs. The pope specifies that this notion of love is the service of charity. In the second and third centuries, this communal commitment to charity distinguished the early Christian communities. Their actions were so prominent and outstanding that civil authorities gave juridical standing to these Christian charitable services.

Benedict XVI draws two important points from the early church’s commitment to loving the poor, the sick, the dying, and other vulnerable populations. First, he asserts

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560 Benedict XVI, World Day of the Sick.
561 Benedict XVI, Austrian Diplomatic Corps.
562 Deus caritas est, §19.
563 Ibid., §19.
564 Ibid., §21–23. Benedict XVI draws attention to several examples in the early centuries of the church where the charitable activities of the Christian faithful influenced society. For example, he points to monasteries that were responsible for the service of charity, the emergence of the diaconia reaching out to the poor and suffering, the witness of Saint Lawrence, and the emperor Julian the Apostate. He also notes Justin Martyr’s teachings that explicitly linked charitable activity with Eucharist (Ibid., §22).
that the church’s nature is expressed in its three-fold responsibility: to proclaim the word of God, to celebrate the sacraments, and to exercise the ministry of charity. Second, “the Church is God’s family in the world…[and] caritas–agape extends beyond the frontiers of the Church.”

In his first observation, by stressing that the church’s deepest nature lays in its ministry of charity, or love, Benedict XVI posits a preference for love over justice. In his subsequent encyclical, Caritas in veritate, he further nuances the relationship between love and justice. Benedict XVI does not deny the urgent need for justice in Deus caritas est. Rather, he envisions justice as flowing primarily from the work of politics, for building a just social and civil order is a political task. He writes, “the pursuit of justice must be a fundamental norm of the State.” He continues, “The just ordering of society and the State is a central responsibility of politics…. Justice is both the aim and

565 Ibid., §25.
566 David Hollenbach critically assesses Caritas in veritate on two fronts: first, for lacking a tighter connection between love and justice, and second, for failing to stress an understanding of love as equal regard and mutual relationship. Hollenbach’s critiques seem to arise from a Christian Realist position, an influential movement in the U.S. from the late 1930s to the 1960s propelled in large part by Reinhold Niebuhr. It was especially critical of idealistic categories of Christian love. While Deus caritas est emphasizes that politics bears the brunt for establishing justice and the church primarily pertains to charity, I maintain that this distinction may be suffering from an unnuanced ecclesiology. Drew Christiansen argues that Benedict XVI’s understanding of the church and love sufficiently engage matters of politics, structural change, and the common good. See, Christiansen, “Metaphysics and Society: a Commentary on Caritas in Veritate,” Theological Studies 71, no. 1 (2010): 6–7.

Nevertheless, Hollenbach repeatedly expresses concern for Benedict XVI’s use of Christian charity in terms of gift, grace, and gratuitousness. The author notes that this involves neither equality nor reciprocity, and he fears that gratuitous giving at the level of international aid can lead to squandering. I read Benedict as presupposing gift theory as it was described in the previous chapter. The notion of the return-gift, I believe adequately addresses Hollenbach’s concerns regarding reciprocity. A foreign country squandering international aid would betray the reception of the gift as gift in just the same way as one who come to receive communion takes the consecrated host and throws it to the ground. Lastly, Hollenbach voices substantial concerns about the reception of this encyclical. He accurately enumerates grave errors and sins on behalf of church leaders whose mishandling of the sex abuse crisis have undermined the Gospel’s command to love. A logician may read this third and final critique as a red herring argument. See, David Hollenbach, “Caritas in Veritate: The Meaning of Love and Urgent Challenges of Justice,” Journal of Catholic Social Thought 8(1), 2011, 171–182.

567 Deus caritas est, §28. The debate weighing the merits and challenges of direct services and the need for justice has been addressed by Richard Ryscavage, “Bring Back Charity,” and Thomas J. Massaro, “Don’t Forget Justice,” respectively found in America 194 no. 9 (March 12, 2006), 14–16, 18–20.
568 Deus caritas est, §26.
the intrinsic criterion of all politics. Politics is more than a mere mechanism for defining the rules of public life: its origin and its goal are found in justice." This begs the question, of course, as to what justice is. Benedict XVI points out that answering this requires practical reason.

Politics and justice rely upon reason, which, as discussed in chapter two, represents but one valid and incomplete way of knowing. Reason needs faith to purify it “since it can never be completely free of the danger of a certain ethical blindness caused by the dazzling effect of power and special interest.” As Benedict XVI points out, “faith liberates reason from its blind spots and therefore helps it to be ever more fully itself.” In chapter two I considered the benefits of faith coupled with reason and technology. Faith presents aspects of truth that technology alone, and its sibling reason, cannot grasp. Similarly then, the just ordering of society and the establishment of structures of justice are not the primary work of the church—the ordained members of the hierarchy. To be clear, this is not to say that the church has little or no concern for justice. Nor does this mean to suggest that the church seeks power over the state or that it endeavors to impose its view on others with differing or no faith. The aim “is simply to

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569 Ibid., §28.
571 Deus caritas est, §28.
572 Perhaps one important detail motivating the sharp distinction here between the Church and the lay faithful in this discussion on the unique roles of Church and State is the fact that ordained Roman Catholic clergy may not hold public office. Benedict XVI envisions the ordained as those who instruct the individuals who are enacting the Church’s charitable activity. In §33 for example, he refers to working with the Church, “and therefore with the Bishop.”
help purify reason and to contribute, here and now, to the acknowledgement and attainment of what is just.”

As one reads this section of *Deus caritas est*, it becomes clearer that Benedict is operating out of a particular ecclesial model. He employs the word “Church” in such a way that it primarily refers to the ordained, especially the bishops and the teaching authority of the church. The laity assume a different role. Elsewhere the pontiff makes explicit reference to the lay faithful. He emphasizes that “the direct duty to work for a just ordering of society…is proper to the lay faithful. As citizens of the State, they are called to take part in public life in a personal capacity…The mission of the lay faithful is therefore to configure social life correctly…” It is not correct to say that the church bears no responsibility, or a remote or limited responsibility for just structures in society. It comes down to which part of the church most especially bears this responsibility.

This explanation has intended to offer one possible interpretation of what Benedict XVI means by purifying reason when he articulates the church’s role in forming human conscience. In tending to a formation of conscience, the church can “stimulate greater insight into the authentic requirements of justice as well as greater readiness to act accordingly, even when this might involve conflict with situations of personal interest.” By focusing on the moral and ethical formation of the human person and her conscience, the church contributes “to the purification of reason and to the reawakening of those moral forces without which just structures are neither established nor prove

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573 *Deus caritas est*, §28.
574 The English translation of the encyclical writes Church with the capital letter.
575 Ibid., §29.
576 Ibid., §28.
effective in the long run.” Stated differently, the purifying role of the church most properly belongs to the bishops and the teaching authority, whereas, the role of implementing just policies and social reform belongs to the laity.

Working toward the establishment of a just ordering of society deserves significant attention, toil, and praise. That said, the justly ordered state in no way diminishes the need for love and the ongoing need for the proclamation of the Gospel by all members of the church.

Benedict XVI notes that ecclesial charity includes three elements: tending to basic and immediate human needs, heartfelt concern, and real action directed toward the other. The pontiff envisions that “in addition to their necessary professional training, these charity workers need a ‘formation of the heart’… As a result, love of neighbor will no longer be for them a commandment imposed, so to speak, from without, but a consequence deriving from their faith, a faith which becomes active through love.”

I will address this notion of a command to love in Part II on the

577 Ibid., §29.
578 Joseph Cardinal Bernardin made a similar observation. Even if the U.S. provided universal access to healthcare, the mission of social justice within Catholic healthcare would not be finished. Bernardin argued, “Universal coverage is not a vague promise or rhetorical preamble to legislation, but requires practical means and sufficient investment to permit everyone to obtain decent health care on a regular basis.” He further remarked, “If justice is a hallmark of our national community, then we must fulfill our obligations in justice to the poor and the underserved first and not last.” Even if real reform is achieved, he argued still, that “we must do what is necessary in order to ensure that our health care delivery system is person centered and has a community focus… The poor, vulnerable, and uninsured persons cannot be denied needed care because the health system refuses to eliminate waste, duplication and bureaucratic costs.” Joseph Bernardin, “Key Concepts of Address to National Press Club,” March 1995, in Selected Works of Joseph Cardinal Bernardin: Homilies and Teaching Documents, Vol. 1, ed. Aphonse P. Spilly, C.P.P.S., (Collegeville, Minnesota: Liturgical Press, 2000), 98-99.

Benedict XVI stresses that Christian love is independent of political parties or ideologies. It must be free and never used for efforts of proselytism. It is never a means to a different end other than love itself. In other words, those who engage in charity “in the Church’s name will never seek to impose the Church’s faith upon others” (Deus caritas est, §31). This was a golden rule of sorts for Dame Saunders. She insisted that St. Christopher’s Hospice be open to all people of faith and to those, like David, with no faith. Different from proselytization, when Christian love is freely given, offered with graciousness and gratuity, it holds the power to change people’s lives, just as it did for Saunders, for David, for Antoni, and countless others. See also, Margaret Visser, The Gift of Thanks: The Roots and Rituals of Gratitude, (Boston: Houghton Mifflin Harcourt, 2009), 123–126.
579 Deus caritas est, §31.
footwashing narrative in John’s gospel. The point to be made is that a human spirit open to others instigates a free response in men and women to engage in actions that benefit not simply one’s self but rather, others. This differs from laws or policies that in effect impose expectations, behaviors, and actions. Such is the role of the state. The church, in seeking to primarily foster love, aims not to impose from the outside but to draw out charitable concern from within the human heart and one’s unique identity as bearing the *Imago Dei*. For example, I cut the grass for my neighbor who is a widower living with congestive heart failure. Because I care for his lawn, he feels more comfortable staying in his own home knowing that others are there to support him with the basic maintenance. In the winter, I shovel the snow off his driveway, which allows the deliveries of his meals and medicines to still reach him. These are not things that I must do; they spring from my free offering of love to him.

In *Deus caritas est*, Pope Benedict XVI sketches a vision of love that transforms societies—regardless of whether the hierarchy is forming the consciences of the laity or the laity enacting the work of politics—the core tenet remains that the ecstasy of love intends to move beyond the confines of the church itself. The pontiff revisits the theme of love in his third and only social encyclical, *Caritas in veritate*. In it he specifically addresses love’s capacity to change organizations and to animate societies and cultures.

The notion of love as an impetus for social change is important for this present work on palliative care because it is apparent that its proponents endeavor to some degree, to change and influence current medical practices.\textsuperscript{580} Love is at the heart of palliative care’s origins. But, as I presented in the first chapter, scholars like Jeffrey Bishop and Sharon Kaufman wonder whether palliative care today can continue to enact the loving

\textsuperscript{580} See for example a previous reference on p. 95, footnote 219.
care that distinguished St. Christopher’s because medicine has brought palliative care under its exclusive domain. Technology’s rubrics of efficiency, effectiveness, quality measurement, and professionalism govern palliative care in medical practice today, not love. It is important to explore how healthcare systems and their programs in palliative care can be animated by love in its Christian sense of charity and agape. I will explore this below because I believe that Catholic healthcare in the U.S. can significantly advance and integrate palliative care services throughout the medical community. Catholic healthcare occupies a prime social and political location as its foundation is the Christian tradition’s healing mission, and it enacts this amid a pluralist society. Its actors, Catholic healthcare systems, are developing palliative care practices and are seeking ways to improve them. Thus, I want to explore Benedict XVI’s argument that Christian love can transform societies beyond the Christian community itself.

The Common Good, Justice, and Solidarity

Benedict XVI grounds his vision of love’s systematic, structural, and transformative power in the practical forms of the common good and justice. He

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581 I do not aim to articulate exactly what a fully flourishing palliative care practice might look like in a healthcare system. Such an endeavor is beyond the insight of one person and demands the gifts and expert skills of many different stakeholders engaging in a discernment process. I am arguing, however, that major systemic change needs to occur in U.S. health policy and insurance practices in order to allow for a radically greater acceptance and practice of palliative care. Concepts from both of Benedict XVI’s encyclicals on love, Deus caritas est and Caritas in veritate, provide a significant argument that articulates how love—understood as agape, gratuity and graciousness, justice, and the common good—must be a foundational driving force for the necessary reform at level of both policy and discrete institutional operations.

582 Benedict XVI, Caritas in veritate, §6–7. With regard to authentic human development, the pontiff draws attention to the importance of justice and the common good. His comments specific to justice build upon his treatment of it in Deus caritas est. He observes that “every society draws up its own system of justice” (Ibid., §6). Charity, however, goes beyond justice while never lacking in justice. Charity demands justice and transcends it. In other words, loving another in charity first entails acting justly toward the other. The pontiff clarifies, “Not only is justice not extraneous to charity, not only is it not an
elaborates more freely on the former describing it as a good sought not for its own sake, “but for the people who belong to the social community and who can only really and effectively pursue their good within it. To desire the common good and strive towards it is a requirement of justice and charity…. The more we strive to secure a common good corresponding to the real needs of our neighbors, the more effectively we love them.”

Earlier in the chapter, I highlighted Pope Benedict XVI’s comments on palliative care. There he identified loving care and accompaniment alongside the elderly and the chronically and terminally ill as a serious need in societies today. So important is the need for palliative care that Benedict XVI identified it as a human right that we all ought to be ready to defend. His prophetic identification of palliative care as a human right implies that he sees it as furthering the common good. Bolstering palliative care services and practices can serve the common good because they necessarily entail one other important variable in the Catholic social tradition—solidarity.

alternative or parallel path to charity; justice is inseparable from charity, and intrinsic to it. Justice is the primary way of charity” (Ibid.).

The connection between justice and love expresses an underlying current of the discussion on eros and agape. See, Gene Outka’s lucid explanation of the interconnectedness in his chapter “Agape and Justice,” and in his own final thoughts on agape in Agape, 74–92, and 291–312. Caritas in veritate, §7. Benedict XVI acknowledges that this encyclical pays tribute to Paul VI’s Populorum progressio, which called for integral human development that included a spiritual or transcendental dimension. See Populorum progressio, §16. Moreover, Caritas in veritate’s use of the common good begins with references found in Gaudium et spes, §26 and 27. It identifies the common good as “the sum of those conditions of the social life which allow social groups and their individual members relatively thorough and ready access to their own fulfillment.” It goes on to say that social groups must take account of “the needs and legitimate aspirations of other groups, and even the general welfare of the entire human family.” Men and women ought to have access to all that is necessary for a truly human life, which beyond food, clothing, shelter, education, employment, and respect, must also include the freedom to act with one’s conscience and religious liberty. See also, Gaudium et spes, §74, and Mater et magistra, §65. These definitions and usages of the common good neglect another key aspect, that of human rights. A tension exists in the tradition regarding how best to articulate the common good. It can refer to the social reality in which men and women participate, and it can refer to aspects of human rights. For example, see David Hollenbach, “Common good,” in New Dictionary of Catholic Social Thought, ed. Judith A Dwyer and Elizabeth L. Montgomery (Collegeville, MN: Liturgical Press, 1994), 194; and Charles Curran, Catholic Social Teaching 1891–Present: A Historical, Theological, and Ethical Analysis (Washington, DC, Georgetown University Press, 2002), 145.
In *Caritas in veritate*, the pope argues for the gift of solidarity as an essential component of the common good. Although his context is largely economic and financial, his concepts nevertheless apply to a variety of contexts including the complexities of healthcare in the U.S. Solidarity enables a virtuous approach to establishing economic equilibrium amidst global imbalance, injustice, and increasing worldwide interdependence.\(^{584}\) The pontiff writes, “if the market is governed solely by the principle of equivalence in value of exchanged goods, it cannot produce the social cohesion that it requires in order to function well. *Without internal forms of solidarity and mutual trust, the market cannot completely fulfill its proper economic function.*\(^{585}\) Solidarity flourishes under the practice of gratuity when the lives of men and women witness to the free and selfless love of the Triune God.

Just as the pontiff argues that the commercial logic that animates most all economic activity does not suffice in the economic realm, I similarly argue that in the realm of medicine and the U.S. healthcare system, efficiency and technology do not suffice. Our healthcare system incentivizes market forces in an effort to bring about desired care outcomes. And yet excellent care necessitates solidarity and mutual trust.\(^{586}\)

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\(^{584}\) The reference to interdependence builds upon a persistent theme in the tradition from *Rerum novarum* to Pope Paul VI’s social encyclical *Populorum progressio* and continuing to the present time. Benedict XVI offers *Caritas in veritate* on the 40\(^{th}\) anniversary of *Populorum progressio* and describes it as “the *Rerum Novarum* of the present age” \(^{58}\).

\(^{585}\) *Caritas in veritate*, §35. Emphasis original to the author.

\(^{586}\) The best definition of solidarity appears in Pope John Paul II’s social encyclical *Sollicitudo rei socialis*, On the Twentieth Anniversary of *Populorum Progressio*, December 30, 1987, §38. Solidarity, it stated, “is not a feeling of vague compassion or shallow distress at the misfortunes of so many people… On the contrary, it is a firm and preserving determination to commit oneself to the common good; that is to say to the good of all and of each individual, because we are all really responsible for all.”
Love that aims to foster a deeper mutual trust between healthcare practitioners and patients is also necessary.\textsuperscript{587}

**Solidarity**

Meghan Clark argues for the centrality of the virtue of solidarity in Catholic social thought. She tests the boundaries of the tradition in new ways by her classification of solidarity as a virtue. The fruit of her work comes from her historical analysis of how the principle of solidarity evolved throughout Catholic social teaching.\textsuperscript{588} For Clark, solidarity “includes not only political or social conditions but also commitment to personal flourishing and the participation in the universal common good.”\textsuperscript{589} It enables the promotion of the common good because it attends to both the individual person and the community. Clark notes that solidarity responds to human interdependence, and yet it operates with “a deep and abiding commitment to the equality, mutuality, and dignity of every member of the human family.”\textsuperscript{590}

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\footnote{587}{The \textit{Ethical and Religious Directives} note that Catholic healthcare institutions must especially assume the role of a community of love when patients and families begin to experience the reality of death (ERD, Introduction to Part Five). It identifies Christian love as the animating principle of health care (ERD, General Introduction). One important aim of these characteristics is to strengthen the relationship between the healthcare practitioner and the patient which requires, “among other things, mutual respect, trust, honest, and appropriate confidentiality…. Neither the health care professional nor the patient acts independently of the other; both participate in the healing process” (ERDs, Introduction to Part Three). This statement implies the necessity of solidarity, of each bearing responsibility to the other in accordance with their particular roles.}

\footnote{588}{Clark reads \textit{Sollicitudo rei socialis} §38 as declaring solidarity as a virtue, an interpretation that is not altogether clear. Moreover, she argues that understanding solidarity as an attitude, a duty, and a virtue are all evidenced in \textit{Caritas in veritate}. Here too, her claim that Benedict XVI identifies this theological principle as a virtue is not without problems. The pontiff notes it as a principle in §58, but not a virtue. Clark’s first two observations that solidarity starts as an attitude and then must develop into a duty are more readily substantiated by the tradition. See, Meghan Clark, \textit{The Vision of Catholic Social Thought: The Virtue of Solidarity and the Praxis of Human Rights} (Minneapolis, MN: Fortress Press, 2014), 101–124.}

\footnote{589}{Ibid., 110.}

\footnote{590}{Ibid., 29.}
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In Clark’s treatment of solidarity the elements of palliative care are all present. The inviolable dignity of the one enduring a life-limiting disease leads to the patient’s right to receive palliative and loving care. The fulfillment of this right arises out of the practice of solidarity. When an individual embraces the duty to live in solidarity with a loved one suffering with a chronic or terminal illness, the one who is sick claims her human right to be cared for. In other words when individuals endeavor to fully live and practice palliative care, it proves Clark’s overall argument that human rights and solidarity are not theoretical categories at odds with one another. They are intrinsically connected and one depends upon the other for fulfillment. By practicing a Christ-like life of solidarity with the vulnerable, the poor, and the marginalized, solidarity in turn, leads to the common good. As described at the onset of this work, palliative care offers care and support to the individual, but never an individual in isolation. Palliative care views the individual person contextually—within community and within a network of relationships. This individual–communal reality implies that notions of common good must be considered.

**Common Good**

In considering the intersection of bioethics and the common good, American theologian Lisa Sowle Cahill defines the latter as “a solidaristic association of persons that is more than the good of individuals in the aggregate. ‘Common good’ says something about social communication and cooperation as essential to the fulfillment of

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591 Ibid., 3.
our very personhood.” Like Benedict XVI and Clark, Cahill notes that a Catholic understanding of common good ties together individual men and women with society. It insists, “that the intrinsic sociality of persons demands their interdependence, communication, solidarity, and co-responsibility.” Cahill’s important contribution to the discourse on healthcare ethics remains her keen awareness that the good of the individual represents but one of several factors necessary for moral analysis. Other contingent factors such as a patient’s spiritual welfare, the cost of medical treatment, the burden on family members and caregivers, all ought to be taken into consideration.

Cahill and her colleague Clark situate their understanding of solidarity and common good within a global framework. I wholly agree with them, and I contend that the fruits that these scholars envision will come when we begin employing the concepts they outline right within our own families. Cahill, for example, notes that even when patients were permitted to consider a variety of contingent factors regarding a course of medical treatment, it was still the patient’s perspective that governed the final analysis. She seems to suggest that when we are a patient facing important decisions about our own health and wellbeing, we have an obligation to consider our relationships—to those who are dependent on us and to those on whom we depend. With an eye toward common good, our moral discernment ought to include our immediate family members, the demands we assume and make on caregivers, the demands and expectations that we make

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594 The *Ethical and Religious Directives* states, “Catholic healthcare ministry seeks to contribute to the common good. The common good is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals” (ERD, Introduction to Part One).
595 Cahill, *Bioethics and the Common Good*, 42.
on our healthcare institutions, our local hospitals and their staff, our insurance companies, our government, and our fellow citizens—nationally and globally. Cahill notes that in the writings of John Paul II, solidarity emerged as a major principle corresponding to interdependence, and thus, he described it as a “firm and persevering determination to commit oneself to the common good.” Solidarity, informed by faith, is able to overcome structures of sin because of its inherently communal dimension. Thus, Cahill proposes that a “bioethics of the common good is that reasoning, judgments and virtues are now more clearly understood to have a social dimension, and to be embodied in and through structures, institutions, and ongoing practices, not only in the ‘choices’ of individual agents.”

This is the work of palliative care inspired and sustained by a practice of faith. Palliative care, seen as loving care in imitation of the ecstatic loving and caring concern of God, can break through the structures of sin embedded in medicalized dying. As previously defined, palliative care entails not just the patient. It strives to understand the patient in her familial and social context, respect her values and goals, and stand in solidarity with her family and other loved ones. Admittedly, the definition could be broader to better reflect a commitment to common good, and yet, even as is, it poses a contrast to autonomy that heavy-handedly dominates secular bioethics. Put differently, as Cahill argues in her larger work, Theological Bioethics, “Christian theological bioethics can and must compete with other equally ‘thick’ and more dominant cultural narratives of liberal individualism, scientific progress, and the market.”

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596 John Paul II, Solicitudo rei socialis, §38.
597 Cahill, Bioethics and the Common Good, 60.
598 Ibid., 65.
599 Cahill, Theological Bioethics, 6.
The question remains, in what ways can palliative care further participate and promote the common good? Cahill offers a helpful starting point as she writes:

The gist of the theological contribution is an understanding of the common good that stresses personal and spiritual values; the social interdependence and contributions of all persons; solidarity in seeking the material, social, and spiritual well-being of all; and a “preferential option” for vulnerable and marginal members of communities and societies.\(^{600}\)

Cahill has further argued that solidarity and the common good can ameliorate injustices experienced by the elderly and dying by emphasizing how social injustices, exclusion, and discrimination deleteriously affect them.\(^{601}\) She signals the need for more ample access to palliative care. In doing so, she implicitly suggests that palliative care can positively address some matters of health injustice and contribute to the common good.

The problem is that the U.S. healthcare system does not support genuine experiences and relationships of solidarity with the frail elderly, the vulnerably sick, the chronically ill, and the dying. There are any number of reasons for this quagmire. Cahill helpfully points to various myths embedded in modernity and its offspring of science, technology, and the market. She also notes the hindrance caused by the American imagination based in an exaggerated illusion of independence.\(^{602}\) Her observations parallel those found in *Caritas in veritate*, as noted above, namely that the market and relationships based on equivalent exchanges fail to produce social cohesion, human trust, mutually enriching relationships, and community.

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\(^{600}\) Ibid., 73.


Cahill evidences the struggle to access health care due to gender, income, race, ethnicity, age, disability, and geography.

\(^{602}\) These various examples share the view that men and women are essential autonomous agents who will experience their fullest flourishing in maximizing their own self-interests Cahill, *Theological Bioethics*, 30–32.
To these observations, I want to add two additional thoughts. First, as argued in chapter two, technology promises to save us. Its deployment of devices and engineered therapies along with pharmaceutics, all expressly aim to keep men and women as independent as possible. This communicates a subtle but powerful counterforce to the notions of community and the need for loving accompaniment—solidarity with others.

For generations the U.S. healthcare system has paid and incentivized doctors on a fee-for-service model. Doctors have been paid for requesting diagnostic tests and performing medical interventions that “do something” to the patient. In contrast, palliative care more commonly involves intimate conversations about a patient’s life, dreams, and goals. It exercises the gift of listening so that possible therapies and interventions will more precisely concord with the patient’s values, ultimate desires, and long-term goals. Such activities are rarely if ever considered reimbursable activities in the fee-for-service payment model. Palliative care more consciously questions the assumption that medical therapies will best meet the desired and expressed goals of the patient. It could be said that palliative care professionals embark on a journey of discernment with patients.

A second observation as to how the U.S. healthcare system obstructs the development of solidarity and thereby weakens medicine’s ability to promote the common good is that we have allowed ourselves to quarantine medical care to a clinical environment. The sick go to hospitals. The frail elderly go to nursing homes. Those of us who are healthy and well, our solidarity with such individuals amounts to an economic exchange when we pay the bills and insurance premiums to keep our loved ones in the hands of others. This may be necessary in many situations, and yet more is needed. Emerging models of palliative care and the experiment before us of the medical home
model, that is medical care that occurs directly in an individual’s own private home, just may begin to open up opportunities for solidarity and the common good.

Two items remain for our consideration. First, I will suggest how palliative care might promote the common good of healthcare for the elderly and the chronically and terminally ill in the U.S. Second, I will point out how the theological aspects of palliative care can strengthen these efforts.

A palliative care service that is able to encounter a patient at the time of a diagnosis or very soon after can begin to build a relationship with the patient and his loved ones. In so doing, it may be able to preserve individual patients from fleeing to a perverse extreme like that of physician-assisted death or euthanasia. It has been said by many patients themselves that death is not what they fear, rather it is the process of dying. Palliative care offered as loving care can address this fear. A hallmark of palliative care is its commitment to honor the values and goals of the individual and to assist the patient and family to live as fully as possible within the limitations of a disease. When this is enacted with a strong commitment to remaining in solidarity with the patient’s sufferings all throughout the disease trajectory and dying process, first and foremost from palliative care professionals and from loved ones, then I believe the common good will be enlarged and exceptionally well served. An opportunity currently presents itself to healthcare systems to involve palliative care as driving force that will benefit the common good.

**Palliative Care and the Common Good**

Palliative care can further the common good of U.S. healthcare by offering care to men and women with life-limiting illnesses and terminal conditions that does not
intractably rely on technology or the device paradigm and that enables deep and genuine connectedness between patients, healthcare practitioners, caregivers, and loved ones.

One way to move in this direction of loving care is to change how we experience medical care and specifically, palliative care. Some experts envision the integration of palliative care into newly emerging models of medicine created by the implementation of the 2010 Affordable Care Act (ACA). The ACA radically alters the systemic structure and financing of healthcare. The federal legislation incentivizes healthcare systems and their physicians to abandon the fee-for-service model that reimbursed doctors and hospitals for each discrete action performed during a patient’s care. Instead, the new legislation encourages accountable care organizations (ACOs) and medical homes. This financing mechanism determines reimbursements based on episodes of care, regardless of what particular diagnostic tools, interventions, or therapies are used. The call for change is driven in part by the exorbitant amount of waste in U.S. healthcare, estimated to be around 30 percent of all healthcare expenditures. Examples include the unnecessary choice of a higher-costing service and specialists, preventable errors, fragmentation in the system, operational inefficiencies, excessive and unnecessary paperwork, insurers’

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603 The U.S. federal government’s Centers for Medicare and Medicaid Services (CMS) defines an ACO as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.” There are several ACO models and participation in them is voluntary. See, Centers for Medicare and Medicaid Services, accessed April 22, 2014, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/.

inefficiencies, and inflated prices of both services and products. Thus, the ACA aims to task ACOs with providing higher quality care at lower costs as they manage entire populations of people.

In a presentation at the Theology and Ethics Colloquium given to a group of healthcare ethicists at the Catholic Health Association in March 2014, Terrence O’Malley, M.D., of Massachusetts General Hospital argued that a palliative care model could best facilitate the aims of an ACO. His vision for a palliative care model echoes much of what is contained in the definition of palliative care presented in the opening chapter. O’Malley averred that such a model represents a new way of thinking about the healthcare professional–patient relationship. At its core, the palliative care model identifies what that patient wants most. The patient’s own needs and goals then, ought to drive the therapies and the interventions that the healthcare practitioner offers. An ongoing problem, according to O’Malley, is one of concordance, or the degree to which the goals, prioritized health concerns, and proposed interventions and outcomes are aligned with the patient’s wishes. More carefully matching medical care and other related services to a patient’s own articulated goals and needs can reduce waste in the healthcare system. A theological bioethics, to borrow Cahill’s term, would advocate for changes in his model to further develop and incorporate concepts such as the virtues of

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605 “Best Care at Lower Cost,” 102. Other examples include excess or unnecessary costs come from overuse of medical or technological intervention by a medical practitioner when evidence-established levels have not been met, or when the medical literature has suggested that a particular practice yields poor or ineffectual medical results.

606 Terrence A. O’Malley, “Treating the Whole Person: ACOs and Integrated Care, presentation given to the Catholic Health Association’s Theology and Ethics Colloquium, Mar. 19, 2014, St. Louis, MO. Attended by the author. Slides of O’Malley’s presentation can be found at: http://www.chausa.org/events/calendar-of-events/theology-and-ethics-colloquium/presentations
prudence and justice to balance his overemphasis on patient autonomy. Additionally, a Catholic approach to this model would want to hear of the patient’s goals and needs alongside the considerations and concerns from his spouse, family, and caregivers. Even so, O’Malley’s model suggests that palliative care possesses the potential to move our society’s care for the chronically and terminally ill in a direction that positively impacts the common good, and the medical literature supports this observation.

Several studies in addition to the lung cancer study cited in the first chapter, indicate two discernable and positive effects of palliative care to further the common good: decreased medical costs and increased patient satisfaction. First, one can readily surmise the benefit of reducing medical cost and waste. From the onset, I must clarify that it could be problematic to glowingly assess palliative care and claim that it benefits the common good simply because it uses fewer financial resources. In some contexts and areas in the world, decreased financial resources in the care for the chronically and terminally ill would be unjust. Yet moral discernment always takes place in a particular context. Financial markers by themselves and without context would be insufficient and vapid markers of the common good. At the same time, the cost of

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607 James Keenan proposes four contemporary cardinal virtues: justice, fidelity, self-care, and prudence. He envisions them serving as a “hinge” to Christian living. Concerning justice, Keenan argues that “in general” men and women as relational beings are called to act in justice. Prudence directs the negotiation that transpires when virtues conflict. It names and prioritizes the claims made by competing goods. See, Daniel J. Harrington and James F. Keenan, Jesus and Virtue Ethics: Building Bridges Between New Testament Studies and Moral Theology (Lanham, MD: Sheed and Ward, 2002), 123–126.

healthcare is one factor that must be considered. As Cahill repeatedly reminds us, and as is validated by the U.S. Catholic Bishops, the economics of healthcare is one important factor among a constellation of variables that must be considered for moral reasoning.\textsuperscript{609}

Given the context of healthcare in the U.S., and specifically the inordinate cost of so-called standardized care for individuals with chronic and terminal conditions, financial measure are one defendable starting point for assessing palliative care’s impact on common good. This country spends far more than any other developed nation on healthcare with outcomes that are no better, and in many instances, worse than most all other nations.\textsuperscript{610} The reality of medicalized dying throughout the last many decades has resulted in approximately one quarter of Medicare expenditures covering costs incurred in the final year of life.\textsuperscript{611} The Dartmouth Atlas of Health Care reports that those with “chronic illness in their last two years of life account for about 32\% of Medicare spending with much of it going toward physician and hospital fees (Medicare Part A and

\textsuperscript{609} Part Two of the \textit{Ethical and Religious Directives} on the Professional-Patient Relationship, explicitly names “cost” as an essential component of free and informed consent for proposed treatments. See, ERD, §27. This is followed by ERD §32, that states “no person should be obliged to submit to a health care procedure that the person has judged…not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.” The ERDs repeat this same phrase “excessive expense on the family or the community” two more times in §56 and 57.

\textsuperscript{610} “U.S. Health in International Perspective: Shorter Lives, Poorer Health,” ed. Steven H. Woolf and Laudan Aron (Washington, DC, The National Academies Press, 2013). The percent of national health expenditures as a percent of the nation’s gross domestic product (GDP) is nearly 18\%. This is among the highest according to the World Bank, and superseded by countries such as Sierra Leone and Libya. \url{http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries/1W?display=default}. The Centers for Medicare and Medicaid Services (CMS) project that healthcare expenditures as a percent of the U.S. GDP will be at 20\% by the next decade. \url{http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html}.

Part B) associated with repeated hospitalizations.612 These dismal statistics indicate that the current healthcare structures in the U.S. not only damage the common good, but they are also severely unjust. If palliative care adequately and appropriately offers care to individuals with life-limiting illnesses and uses fewer financial resources in the process, then it seems that it participates in building up the common good. Recall that for Cahill, the common good insists on our interdependence and co-responsibilities. In the context just presented, we have a responsibility to resist using any more resources than are necessary. As presented in the second chapter’s explication of a Christian anthropology, we are not isolated individuals. We live in community, and our actions and decisions ought to take others into account.

A second positive effect of palliative care is high patient satisfaction. Trying to gauge the sentiment and approval of those served by a particular health institution reflects modernity’s emphasis on the individual subject. Just as I noted there could be problems allowing financial dashboards to wholly determine palliative care’s contribution to the common good, there is reason to raise a skeptical eye at customer satisfaction surveys. Assessing the insatiable appetite of the American consumer has inherent limitations despite the fact of the growing weight these mechanisms carry in healthcare. At the same time, the import of increased patient satisfaction particularly with regard to palliative care should not be overlooked.

Patient satisfaction scores could be secular indicators for the virtue of solidarity. Positive experiences with a particular clinic, hospital, or healthcare system can foster deeper trust and therefore a stronger sense of solidarity. Feedback from patients

themselves may reveal patterns of injustice and disparity. Such information can point healthcare practitioners and administrators to areas where solidarity is lacking. This may be especially true for palliative care because it relies on the bonds of trust between the patient and an entire network of people. Striving to increase patient satisfaction may represent small, and admittedly inadequate, yet important steps toward greater solidarity, which as Clark and Cahill argued, redounds to the common good.

If palliative care became more widely accepted and practiced then positive contributions to the common good could include a decrease in physician-assisted death—an action that forthrightly rejects the possibility of solidarity with the sick and dying. Local parish communities could initiate and provide increased support and visitation to the homebound and chronically ill, parish nursing programs, advanced care planning seminars, and resources and respite for family caregivers. Research indicates that when healthcare institutions partner with local faith communities, the healthcare institution builds important bonds of trust, especially within minority communities.613 This points to the possibility that palliative care programs tied to local and parish communities could reduce end-of-life health disparities.614

These represent but a few examples of how palliative care can concretely contribute to the common good of healthcare in the U.S. Throughout this work, I have noted obstacles to palliative care. Many palliative care advocates argue for changes at


614 The term disparity in the healthcare context refers to racial, ethnic, social, or class differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention. It witnesses the effects of prejudice and stigma. See, Brian D Smedley, Adrienne Y. Stith, and Alan R. Nelson, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, (Washington D.C.: National Academic Press, 2003), 3–4.
the level of public policy to address such challenges. They contend that policy changes will open the door to more fully develop palliative care programs and thus enable a more comprehensive assessment of its benefits. For example, policies could guarantee the inclusion of wide-ranging palliative care services as a guaranteed benefit for diagnosis of chronic and terminal illness. This could potentially represent a sizeable step away from some forms of medicalized dying and steps toward our common good. Similar provisions exist for those determined to qualify for hospice, yet this model dating back to legislation passed in 1982, needs reforms that respond to the current practices of medicine and society’s health needs.

The Catholic Health Association (CHA) contends that a major obstacle to palliative care in the U.S. is how healthcare is delivered. The fee-for-service reimbursement system has long rewarded the device paradigm and highly specialized medical practices. The CHA notes that our system does not adequately compensate for things like primary care or cognitive services, meaning the time spent in detailed communication with a patient—an important keystone for palliative care. In fact, the most fundamental service of palliative care, the goals of care meeting, is not reimbursed at all.\(^{615}\) The CHA suggests several policy changes at the federal level to benefit palliative care such as funding to the National Institute of Health to study palliative care, standards to integrate palliative care into the education systems for healthcare professionals, and federal and private funding for palliative care education, fellowships, and junior faculty.\(^{616}\)


\(^{616}\) Spugnardi, “Policy Changes,” 50–51. The author also presents two suggestions for implementation at the state level. The first is the POLST program—Physician Orders for Life-Sustaining
Lisa Cahill also raises considerations for policy changes that would positively contribute to the common good. Her insights are the fruit of her conviction, passionately and convincingly made, that theology must recover its prophetic voice and enter into policy debates. She believes, “theologians ought to stick to their own convictions, remain unapologetically theological in orientation, while still seeking common cause and building a common language with all who are similarly committed to health care justice.”

In the vision she lays out, one sees a model that realizes what Benedict XVI described in Deus caritas est—that justice is foremost the work of the polis, the work of lay men and women who have been formed by the Catholic tradition in all its richness.

Cahill draws from examples taken from around the world to make compelling suggestions regarding health reform in U.S. For example, in Singapore, adult children receive tax rebates and preferential housing choices to reside with their aging parents. Cahill calls for more ample access and opportunities for home health care, adult day care, and senior recreation resources in addition to support networks for caregivers. Those caring for the vulnerably ill and dying often suffer from isolation, stress, and economic burdens. Cahill’s suggestions largely focus on human and relational aspects of care, similar to the model of care operative at St. Christopher’s and developed by Dame Saunders. Cahill notes that medical and technical assistance, although helpful, “are not the most powerful sources of human meaning, nor do they provide the most effective treatments. Second, they point to state laws in California and New York, although different in their detail, the laws protect a physician’s time to facilitate discussions of end-of-life options with terminally ill patients, and the physician would receive reimbursed payment for such conversations.

Cahill, Theological Bioethics, 18.

Ibid., 79–80.
means to address the losses that may be associated with illness, decline, and impending death.”

These examples of strengthening palliative care beyond the clinical environment and scientific matrices provide at least two important contributions to this conversation. First, it is creative ideas such as these that foreclose the momentum of palliative care from collapsing into medicalized dying. When the focus is first and foremost on the human person and recognizing both, her relations with other individuals and her own human dignity, then we can stymie the influence of the technological paradigm. Second, these examples demonstrate the positive effect of a theological anthropology in contrast to medical or clinical view of the individual, which as I have argued is overly influenced by the essence of technology. Cahill maintains that theology provides an important contribution to shaping society and public policy. She argues that it provides, “an understanding of the common good that stresses personal and spiritual values; the social interdependence and contributions of all persons; solidarity in seeking the material, social, and spiritual well-being of all; and a “preferential option” for vulnerable and marginal members of communities and societies.”

I wholeheartedly concur with Cahill’s vision for a “thick” theological contribution to unapologetically engage public discourse and to promote a “participatory bioethics.” She insists that Christian theological bioethics should foster social practices that “reintegrate the ill and dying with spiritual avenues of transcendence and with communal structures of support.” Cahill, however, does not articulate precisely what grounds

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619 Ibid., 80.
620 Ibid., 73.
621 Ibid., 13–42.
622 Ibid., 72.
participatory bioethics. More to the point, she has no substantial mention of Jesus Christ, the paschal mystery, the Holy Spirit, the resurrection of the dead, the Gospels or the rest of the scriptures for that matter. A thick theological contribution to the discourse of bioethics that endeavors to take on the steely structures of institutional sin demands the strength and the force of the deepest and most enduring aspects of the Christian tradition—the Eucharist. The call from *Gaudium et spes* to participate in the just ordering of society came after the Council’s first call to participation—to participate fully, consciously, and actively in the liturgy of the Church. The task, specifically for Catholic ethicists, is to wed *Gaudium et spes* with *Sacrosanctum concilium.*623 The acceptance, inclusion, and salvation that the elderly, vulnerably ill, and dying encounter in their participation in the sacramental-liturgical life of the Church witnesses to their hoped for acceptance, inclusion, and fuller participation in society and among their own loving relationships. Christians seeking to engage social change concerning how our healthcare system cares for the vulnerably and terminally ill must ground their efforts in an encounter with the living God who then sends them out to cultivate God’s Reign. It is for this reason that I conclude this section on love, palliative care, and the common good by examining how women religious whose lives are dedicated to prayer and committed to living out the Gospel, effected systemic change in the U.S. healthcare system. Finally, Part II concludes the chapter with a reflection on the Johannine footwashing narrative—a story that tells of the disciples’ encounter with Jesus as love incarnate. He lavishes loving care upon them, and then from this sacramental encounter he commands them to go out into public to do the same.

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How Love Changed the Landscape of American Healthcare

Lest my suggestion that palliative care can serve the common good in the context of the U.S. healthcare system fail to stand up against critiques from realists and pragmatists, I point to a recent example whereby the Christian understanding of love directly and positively impacted the common good for Americans.

Love—understood in its Christian contexts of agape and caritas—effected institutional change not only in the creative work of Dame Saunders, but also more recently in the U.S. when the Catholic Health Association (CHA) arduously advocated for the Affordable Care Act (ACA) in 2010.

Love, in its macro dimensions, acted as a driving force that motivated the women religious to give their overwhelming support to the legislation during its contentious debate.

Catholics found themselves to be pivotal players in the debate over the ACA. Some Catholics lauded the social justice implications of providing access to care for millions more Americans, while others warned of the potential scandal and injustice of using federal funds for abortions. The United States Conference of Catholic Bishops believed the Senate’s bill lacked strong enough protections against federal funding of abortion.

In the midst of the debate in March of 2010, the CHA broke with the U.S.

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624 For other examples of how charity has impacted matters of public policy and international relations, see “From Charity to Advocacy” in Marvin L. Krier Mich, Catholic Social Teaching and Movements (Mystic, CT: Twenty-Third Publications, 1998), 333–346.

625 For several decades, social ethicists, healthcare ethicists, and leaders in Catholic healthcare have pushed for universal coverage. See, Philip S. Keane, Catholicism and Health-Care Justice: Problems, Potential, and Solutions, (New York: Paulist Press, 2002) and also by Keane, Health Care Reform: A Catholic View (New York, Paulist, Press, 1993).

bishops by publicly supporting the Senate bill. CHA President and CEO, Sister Carol Keehan, DC, accentuated the matters of justice and the common good while also maintaining that the proposed legislation did not allow the use of taxpayer monies to pay for abortion services. She emphasized how the bill would give 31 million Americans health coverage in addition to $250 million for vulnerable, pregnant, or parenting women. 627

On the night of March 21, 2010, the House passed the bill. Two days later President Obama signed into law the Affordable Care Act. On March 24, 2010, President Obama issued an Executive Order reinforcing the long-standing policy restricting federal funds for abortions. 628 In the aftermath of the legislation’s passage, it appeared that Catholic healthcare, specifically the CHA, had played a critically pivotal role. Sr. Carol was the only non-politician or non-presidential advisor to receive one of the twenty-one pens used by President Obama in the bill signing ceremony. 629

My point is that thousands of women religious—whose communities, congregations, and former sisters have lavished love at the bedside for countless Americans for over two centuries—transformed their commitments of individual loving care for ill and dying patients to successfully advocate for systemic change. 630 The precipitous decline in community membership since the 1960s meant that fewer sisters

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actually served in the hospitals. The few that did remain largely assumed roles in administration. Some who had cared at the bedside for years as nurse advocates reimagined and reasserted their role as advocate for systemic and political change. For example, in the history of the Sisters of Charity of Leavenworth (SCL), Sister Marie Brinkman, SCL, recounts several instances where women in her community used the experiences they gained from their community’s hospitals to fuel their efforts for wider and more impactful social change.631 The community’s Social Justice Office, created in 1987, served as a model for their healthcare ministry, the Sisters of Charity of Leavenworth Health System (SCLHS). Sister Judith Jackson, SCL, had been a chaplain serving at the bedsides of patients years before she became Vice President for Sponsorship and Mission at SCLHS. During her tenure, she created a full time position for political advocacy. Sr. Judith along with her advocacy counsel, crafted the “SCLHS Statement of Principles On Health Reform 2009.”632 This came more than two decades after Sister Macrina Ryan, president of SCLHS (1980-1992) made national healthcare legislation a priority for SCLHS.633 This is but one example of a mid-sized Catholic health system that publicly called for substantial reforms in overhauling the U.S medical

631 Marie Brinkman, SCL, Emerging Frontiers: Renewal In the Life of Women Religious: sisters of Charity of Leavenworth, 1955-2005, (New York: Paulist Press, 2008), 306. Brinkman tells of Sister Kathryn O’Neill who had twenty-five years of experience as a registered nurse, supervisor, and administrator before she established state-run public health services in Wyoming and Montana. Sister Alice Marie Schwieder, SCL, was the first woman elected President of the Montana Hospital Association and later the Wyoming Hospital Association. Sister Michael Pantenberg, SCL, also served the Montana Hospital Association as its chairperson (Ibid., 276). Sister Elizabeth Henry was the Secretary of the Missouri Association of Home Health Agencies. Others, such as Sister Marie de Paul Combo, an educator and an experienced advocate in the civil rights movement in the 1960s, applied her skills to the community’s newly created Social Justice Office in 1987 (Ibid., 327).

632 The statement advocated for universal access for all, changes at systemic levels to reduce costs and increase quality, an end of fee-for-service, and innovative payment reforms of Medicare. See the SCLHS’s health policy platform available on their organization’s website: http://www.sclhealthsystem.org/workfiles/SCLHSHealthReformPrinciples.pdf, accessed Oct. 27, 2011.

633 Brinkman, Emerging Frontiers, 256.
delivery and insurance systems.\textsuperscript{634} The example also demonstrates how over the course of time, some women religious transitioned the solidarity they once expressed at the patient bedside to calls for systemic reforms to ameliorate the common good of healthcare in the U.S.

Appealing to the ACA example demonstrates the real possibility for change in future health policy.\textsuperscript{635} The work of the CHA and its members stands as a beacon of hope for the systemic changes that are and will be necessary for palliative care to flourish within the U.S. healthcare system. Changes to broaden palliative care, at least in terms of access and practice, will be needed at the level of public policy primarily to more appropriately and justly reimburse for these services. Further transformations will also be needed within individual health systems and physician practices to implement strategies and programs that meet the needs of their patient populations, similar to the model that Dr. O’Malley described above.

Women religious have been effective in pursuing social change, like that of the ACA, because their very lives entail vows of poverty that signal a public commitment to solidarity with the poor. Moreover, women religious profess a commitment to prayer. This means their lives are shaped by the liturgical rhythms that follow the paschal

\textsuperscript{634} Outside of the SCLs a most notable woman enshrined in U.S. history was Mother Joseph Pariseau, a Sister of Providence. She was responsible for designing and building eleven hospitals in the West and Northwest. The State of Washington selected a bronze image of her kneeling to represent their state in the National Statuary Hall in the US Capitol building. See, Sister Mary of the Blessed Sacrament McCrosson in collaboration with Sister Mary Leopoldine and Sister Maria Theresa, \textit{The Bell and the River} (Palo Alto, CA: Pacific Books, 1957).

\textsuperscript{635} Much remains unknown regarding the law’s long-term effect. Also, the law contains many shortcomings and is no panacea. Among the most glaring problems are the market-driven factors that some hope will spur improvements and efficiencies. The ACA remains an important step toward promoting the common good in U.S. healthcare. The signs indicating a positive effect to the common good include the number of people who gain health insurance, particularly those who previously did not have it. Additional features include the abolishing of denying health insurance due to preexisting conditions, outlawing price differentials based on gender, and the expansion of Medicaid. The importance of the latter is that it signals that the poorest and neediest are gaining access to medical services and related support for their health and well being.
mystery. In other words, their lives are steeped in the ongoing ebb and flow of the pattern of life, death, and new life that is the very pulse of the Triune God. These same presuppositions are not and will not be automatically presumed by lay business leaders in Catholic healthcare. It certainly cannot be presumed of those who have no practice of faith. This is not to say that lay leaders do not bring their own gifts or that the lives of lay men and women are not in fact also formed and deeply guided by paschal mystery. It is to say that lay executives in Catholic healthcare and other Catholic institutions have obstacles to confront that women religious do not in order to effect social change motivated by love. The lay executives have to clearly demonstrate how their proposals are not merely economic or utilitarian. They may need to stress, at least internally to the Catholic sponsored organization, how their actions and proposals reveal the ecstatic loving concern of the Triune God. Lives formed by God’s gracious and gratuitous love communicated through the sacraments is a critical detail that must be carried forward as in the lives of the lay men and women of Catholic healthcare. At the very least, it must be lived out by all on sponsorship boards, and many comprising boards of directors, system executives, local hospital executives, and some physicians. The difference between the lives of vowed women religious and lay leaders of Catholic healthcare must not be underestimated. 636 Yet, these are concerns that cannot and ought not to be resolved here in these pages, but by and among others in a process of theological reflection and discernment within Catholic institutions.

636 One must not be confused by the fact that ecclesially speaking, women religious are lay persons. One distinguishing feature, however, is that as members of a religious community, women religious live by a particular charism that guides their life’s work and ministry. Their communities initiated healthcare ministries as expressions of their charisms. However, given the rapid changes in healthcare and the dramatic shift from women religious to lay leadership, appealing to the founding congregation’s charism is insufficient. See, Susan K. Wood, “Health Care Sponsorship: From Charism to Ecclesial Ministry,” Health Progress 90, no. 5 (Sept.-Oct. 2009): 45–48.
In *Deus caritas est* Pope Benedict XVI stressed that Christian charity is part of the church’s own nature and an indispensable expression of the church’s being, precisely because it presupposes and is inseparable from the proclamation of the word and the celebration of the sacraments.\(^637\) Stated differently, a key aspect of the successful advocacy of the women religious in calling for charity-inspired reforms in healthcare was inextricably bound to the fact that their lives have been formed by the good news of the scriptures and nourished time and again by God’s own gracious and gratuitous love offered in the sacraments. From these constitutive actions of the Catholic-Christian life, \textit{“caritas–agape extends beyond the frontiers of the Church.”}\(^638\) The nature of Catholic healthcare in the U.S. necessarily extends far beyond the Church’s frontiers, but it cannot do so without the previous three ingredients of word, sacrament, and charity.

Benedict XVI notes that Jesus’ act of selfless love poured out on the cross endures through the eucharist. It draws us into his love, and \textit{“we enter into the very dynamic of his self-giving.”}\(^639\) Thus, the pontiff stresses the inherently social and ecstatic dimension of Eucharist as it \textit{“draws me out of myself toward [others], and thus also toward unity with all Christians. We become ‘one body,’ completely joined in a single existence. Love of God and love of neighbor are now truly united.”}\(^640\) Just as the opening of this chapter noted how \textit{eros} and \textit{agape} are drawn together, so too does love of neighbor become bound up in love of God. Benedict XVI explains, \textit{“Worship’ itself, Eucharistic communion, includes the reality both of being loved and of loving others in turn. A Eucharist which does not pass over into the concrete practice of love is intrinsically

\(^{637}\) *Deus caritas est*, §25.


fragmented. Conversely…the ‘commandment’ of love is only possible because it is more than a requirement. Love can be ‘commanded’ because it has first been given.”

_Agape_ became a term for Eucharist. Dame Saunders concretely manifested her love for the suffering and dying by establishing St. Christopher’s, and driving this vision was her experience of being loved by God and having found love with David and Antoni. Moreover, the eucharistic chapel at the very heart of St. Christopher’s stands as a constant reminder and living sign that God’s ecstatic love pours over into our lives, and that we are to be the conduits of that same love for one another. Benedict XVI points to the commandment to love—a scriptural reference found in John’s Gospel that appears in the footwashing narrative. The pontiff references John 13:1–3 as a paradigm for the church’s charitable activity in the world and a manifestation of trinitarian love. In addition, Chauvet and many other theologians point to the footwashing as rich eucharistic narrative. Thus, to conclude the chapter, I reflect on this passage in John’s Gospel and consider it liturgical ritualization in the Holy Thursday liturgy. The richness of this rite provides several points of contact with palliative care: it provides a profound embodiment of solidarity, it ritualizes loving care to individuals and community, it unfolds in a eucharistic context, and then it commands believers to love as freely and gratuitously as they have been loved.

**Part II – Holy Thursday as a Hermeneutic for Loving Care**

In the final section of this chapter, I highlight the washing of feet that occurs at the Holy Thursday Evening Mass of the Lord’s Supper,\(^{642}\) as it weaves together a tapestry

\(^{641}\) Ibid., §14.
of themes ranging from death, humble service, and imitation of Christ Jesus to triumph and love. I will draw from only a few key concepts in the Johannine footwashing passage and then comment on the ritual itself as contained in the *Roman Missal*, including the antiphons that amplify the meaning of the ritual itself. What will become clear is how both the scriptures and the ritual intend to move the worshippers into ethical and virtuous living. I highlight the Holy Thursday footwashing ritual and its array of accompanying scriptures because its center is love. It so clearly demonstrates the gift of the virtue of love being given to the gathered body, and then it commands them to carry this healing love into the world through their own actions. The love displayed through the Holy Thursday liturgy is victorious and glorious; even more, it is individual and communal. Thus, the Holy Thursday footwashing ritual contains paradigmatic elements worthy of reflection for anyone involved with palliative care, including both, patients of palliative care and its practitioners.


Chapter 13 of John’s gospel begins the second half of the book, which scholars call the Book of Glory. Raymond Brown describes it as the upward swing of the

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642 This name for the liturgy that commences the Paschal Triduum in the Roman Catholic tradition, particularly the qualifier “evening Mass,” distinguishes it from the Chrism Mass, which may take place in the morning of the Thursday in Holy Week. Other Christian traditions name this celebration Maundy Thursday after the *mandatum*, or the command Jesus gives in John 13:15, 34 to do as he has done. This analysis of Holy Thursday will not be comprehensive. Many important images and issues will be omitted, including the pastoral quandaries regarding number and gender of those of those whose feet may be washed. For an excellent analysis of contemporary controversies and pastoral practices, including an excellent discussion on the participation of women in the footwashing, see, Peter Jeffery’s article, “Mandatum Novum Do Vobis: Toward a Renewal of the Holy Thursday Footwashing Rite,” *Worship* 64, no. 2 (1990): 107–141.

643 The Lectionary limits the passage to John 13:1–15. Most of the scholarly literature considers vv. 1–20 as a unit, even though most scripture scholars concur that significant redaction has occurred.
pendulum as it leads to Jesus being lifted up on the cross, physically taken up off the earth, and continuing in his resurrection and ascension. This small insight can be instructive for those involved in palliative care. The latter half of the book of John tells its readers that even as Jesus makes his way into his passion and death, the overall trajectory is one toward glory. This represents one of the key paradoxes of the Christian faith. It is an instructive view of death. So often today, when a disease shows its growing strength in a patient’s body it is not uncommon for family and observers to comment how the patient is “going down hill,” or “losing ground.” The image is one of a downward trajectory, and yet the evangelist describes Jesus’ death, and hence, implicitly our own, as an upward movement.

The footwashing narrative begins with death expressed in a context of love. Jesus is aware that he is going to “pass from this world to the Father.” This opening verse further signals Jesus’ imminent death when it ends saying “he loved them to the very end,” a phrase that refers to the end of his life. The paradox, so paradigmatic of Christianity, reveals itself as this book about glory opens by foreshadowing death. The paradox intensifies as the opening verse weaves death together with love. By twice appealing to love in v. 1b, the evangelist stresses that everything that follows, “to the very end,”

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Ruth Edwards uses the historical-critical method augmented by an awareness of reader-response criticism and her belief that attention given to the literary, social, historical, and religious context of the text is important. Furthermore, her work addresses the contemporary issues of anti-Semitism and anti-Judaism that some read in John’s gospel. See, Discovering John (London: SPCK, 2003).

645 Brown, The Gospel According to John, 550. Brown notes that “to the very end” has a twofold meaning that signals “utterly, completely” as well as “to the end of life.” The author also notes that a related verb (telein) appears in the text at the very moment of Jesus’ death. This signifies that the text is really speaking of death and not some fantastical passage from this world to the next.
reflects the depths of Jesus’ love. Like most human narratives of death, this one too is a love story.

Although a standard interpretation of this passage has been to read it as an example of self-sacrificing humility that Christians ought to imitate, Brown interprets the footwashing “as a prophetic action symbolizing Jesus’ death and humiliation for the salvation of others.”

He contends that v. 1 serves as an introduction that foreshadows death, as Jesus “knew that his hour had come to pass from this world to the Father.” This opening prepares the reader to imagine how the washing of the feet (vv. 2–11) could signal how Jesus’ death will serve those whom he loves. Stated differently, the footwashing symbolizes Jesus’ saving action. Thus, as I probe the theological significance of this scripture passage and its ritual enactment in today’s liturgy, it is important to recall that in the previous chapter I examined how Susan Wood followed by Bruce Morrill posited that salvation entails and implies healing. That is to say, as the footwashing narrative involves death, love, and Jesus’ saving actions, it therefore, also entails healing—a loving healing that the Christian community is called to imitate.

Furthermore, the healing dimension becomes all the more clear when viewing it within the larger Johannine narrative of the Last Supper. Some theologians interpret the

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646 Ibid., 562. The traditional interpretation represents a valid reading, especially given the explicit the mimetic nature of Jesus’ actions in vv. 14–17.


footwashing as itself eucharistic. While Brown remains skeptical of this suggested equivalence, Rudolf Schnackenburg’s thoroughgoing scrutiny on the silence surrounding the institution of the Eucharist in the fourth gospel’s Last Supper conjectures that it is reasonable to view the washing of the feet as an interpretation of the eucharist.

The point I want to make beyond these important scriptural and theological discussions on the Gospel of John is twofold. First, even though an explicit enactment of one of the traditional seven sacraments remains nebulous in John 13, the text reveals a renegotiated

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648 Peter Henrici, “‘Do this in remembrance of me:’ The sacrifice of Christ and the sacrifice of the faithful,” *Communio* 12 (Summer 1985), 146–157. Henrici compellingly argues for a close parallelism between the institution narrative (1 Cor 11:24), the sacrificial attitude of Jesus’ self deliverance to the Father in the synoptic gospels, and the Johannine command (John 13:15) following the washing of the feet combined with John’s vision of giving oneself in loving service to others. He writes, “As it is well known, the Gospel of John does not recount the institution of the eucharist. In its place John has the washing of the feet. This substitution can hardly be coincidental, especially when the great speech on the Bread of Life (John 6) has already referred expressly to the eucharist. But the account of the washing of the feet also concludes with a command to repeat, one even more emphatic than that of the synoptic” (Ibid., 149). The author stresses that both, the Johannine footwashing and the synoptic passover meal, are eucharistic because they entail a liturgical action performed in love that leads Christian faithful from the ritual itself back to their daily routine so that they may express Christ Jesus in their daily life.

The eucharistic connection of John 13 emerges more clearly in Jesus’ narrative immediately following the footwashing. Verses 26–27 speak of the morsel and Jesus’ betrayer. Francis Moloney presents a persuasive case that while baptism and Eucharist are not mentioned in John 13, they both form the background, not the foreground of the narrative. He finds that “there are sufficient indications in the text itself to argue that a subtheme to the meal...in vv. 21–38 is eucharistic, just as a subtheme to the footwashing and the gift of example in vv. 1–17 was baptismal. The whole of 13:1–38 indicates that Jesus shows the quality of his love—a love which makes God known—by choosing, forming, sending out, and nourishing his disciples of all times, catching them up in the rhythm of his own self-giving life and death” p. 254. See, Francis Moloney, “A Sacramental Reading of John 13:1–38” *Catholic Biblical Quarterly* 52, no. 2 (1991): 237–256.

649 Brown describes three discrete interpretations of Johannine sacramentalism. First, some scholars deny any reference to sacraments in John’s gospel, especially baptism and eucharist. An extreme position in this vein characterizes John as anti-sacramental. Second, there are others who see the fourth gospel as the most sacramental for its highly symbolic references to baptism and eucharist. These scholars point to the Bread of Life discourse in Chapter 6 and the imagery of light and darkness or death and new life found, for example, in the stories of Nicodemus (Jn. 3:1–21) and the raising of Lazarus (John 11:28–44). Thirdly, Brown notes an alternative position that sees Jesus in the Johannine gospel as prophetically anticipating the sacraments. See Raymond E. Brown, *An Introduction to the New Testament* (New York: Doubleday, 1997) 377–378.

650 Schnackenburg, *The Gospel according to St. John*, 33–47. The author summarizes seven different interpretations among Johannine scholars regarding the gospel’s sacramentality or lack thereof. He judges the two extreme views as insufficiently based—the anti-sacramental view championed largely by Bultmann and the highly symbolic interpretation advocated by Cullmann (Ibid., 42–44). He writes, “As far as the replacement of the account of the institution of the Eucharist by the washing of the feet is concerned, the important questions remain open” (Ibid., 44–45). He notes that John omits many details of Jesus’ life as compared to the Synoptics, for John displays greater concern for interpretation of Jesus’ life and action and for deep Christological insight.
understanding of death in much the same way Morrill described how the sacraments enact a renegotiated understanding of healing. Second, just as the footwashing aided the disciples’ renegotiation, rituals of footwashing and Eucharist remain necessary and important today for our own renegotiated understandings of life, healing, and death. A look at how this renegotiation unfolds in the scriptures is worth deeper explanation.

Brown writes that the footwashing “dramatically acts out the significance of Jesus’ death—it is a death that cleanses the disciples and gives them a heritage with him.” He buttresses his claim with content that follows in the Last Discourse where Jesus repeatedly reassures the disciples that his death is not the end. He is going “to the Father” (13:1), and “he will return (in resurrection, in indwelling, in the Paraclete, in the parousia), and his return will be marked by peace and joy. Jesus’ return will enable the disciples to dwell in union with him [15:1-17], a union similar to his own union with the Father [17:21].” To engineer a renegotiated understanding of death, Jesus relied on the faith that the disciples had placed in him, and he gave them deep and powerful hope that something wonderful awaited them after death. He stirred their hope with his humble act of service motivated by love. Jesus, the Teacher and Lord, takes the form of a servant with a basin and towel to wash his companions’ feet. It is an act of love that foreshadows the love of Jesus’ salvific death.

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652 Ibid. Mary Coloe notes that it is only later, after the resurrection, when the community has received the Holy Spirit that the fullness of understanding becomes possible. She views the footwashing as an invitation to participate with Jesus “in his ‘hour.’” As Jesus moves from this world to the Father, they too are to be involved. Jesus gives them an example, not one of servitude, but rather one of love. Thus, the attitude of love is essential for all who hope to enjoy God’s dwelling. Mary L. Coloe, “Welcome to the Household of God: The Foot Washing in John 13,” *Catholic Biblical Quarterly*, 66 (2004): 400–415.

The latter portion of the passage, vv. 12–20, interprets the footwashing for the disciples, and it is likely that John intended this explanation for the hearers of this message. Most notably, vv. 14–15 present the *mandatum*, the command that the disciples must wash one another’s feet following the example given to them. Jesuit scholars Daniel Harrington and James Keenan employ their expertise in biblical studies and moral theology respectively, to explain that throughout the scriptures, “love is not so much an ethical principle as it is a response to the experience of God’s love for us… The persistent message of the Bible is that God has loved us first, and the proper response to God’s love for us is to love God and to love the neighbor.” Thus charity, or love, becomes the prime impetus for the Christian community, especially for those seeking to live and grow in virtue. Harrington and Keenan present an understanding of the Christian life congruent with Chauvetian model. The encounter with God’s gift moves the Christian faithful to give in return primarily through the actions of their lives. Jesus’ command to the disciples to wash one another’s feet is like an urgent invitation to more fully experience the gift he has shared with them. They will do this by their own embodiment and imitation of similar and future actions. Christian communities have ritualized this

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654 Brown notes how John 25:12–13, with its command to love to the point of laying down one’s life for others, excellently comments on the mandate here in 13:15. Furthermore, Brown notes that both interpretations of the footwashing, 6–10 and 12–17 end with the awareness that not everyone will follow this command and not everyone has been touched by Jesus’ actions, namely Judas (Ibid., 569–570).
656 Ibid., 84.
command in one form or another for centuries. Today, it most conspicuously remains as an integral part of Holy Thursday’s Mass of the Lord’s Supper.

Holy Thursday’s Ritual Washing of Feet

Examining the contemporary ritual as it is today in the Roman Catholic liturgy provides an important vantage missed by a scriptural exegesis alone. James Farwell observes how the Triduum powerfully impacts those in the worshipping body through its ritualized gestures. Actions such as footwashing, processing, or kissing the cross, connected with the words of scripture and orations powerfully form the worshippers and intimately connect them with the paschal mystery. Farwell argues that the ritual, “actualizes or enacts the real relation between the community and the Christ whom they serve.” In other words, merely reading the scriptures and recalling what they say remains a one-dimensional encounter with the living Christ. The ritual draws the worshipping body into an encounter with Christ, who loves them and commands them just as he did for his disciples. Similar to Brown’s argument, Farwell contends that the footwashing mandatum is more than a reminder to be good servants. It stands as a powerful moment of communal transformation as it “enacts or ‘actualizes’…this saving attitude or disposition toward the world.” The ritual is neither completely new nor is it mere mimesis, but rather, it is thoroughly anamnesis. In other words, the enacted ritual

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658 Beyond the liturgical prominence the footwashing enjoys today in the reformed rites of the Triduum, Jeffery explains how it has been a practice within monastic communities, including communities of women. Jeffery, “Mandatum Novum Do Vobis,” 114–117, 124–128.
659 James W. Farwell, This is the Night: Suffering Salvation, and the Liturgies of Holy Week (New York: T&T Clark, 2005), 101.
660 Farwell, 102.
661 In the Roman Catholic tradition, anamnesis is one major structural element of the Eucharistic Prayer. It recalls Jesus’ death, resurrection, and ascension. It is more than memory, however. As the
creates the encounter with Christ, and much like the Emmaus story. It sends members of this worshipping community out to transform their society with love. I will elaborate further on the communal dimension of the footwashing below.

It is important however, to note that the words and prayers add an essential element to the ritual actions themselves. When enacting the ritual, the *Roman Missal* offers seven antiphons for the worshipping body to chant or sing. The traditional list of antiphons began with John 13:34, “I give you a new commandment, that you love one another as I have loved you, says the Lord.” While washing feet, the choir and others sing this antiphon that urges Christians to love one another. Together the ritual and songful words exemplify the inextricable bond of Christian love with service. Here before the gathered faithful is an image of loving care. The anamnetic dimension of the ritual both reminds and makes present to the worshipping body the loving care that God showers upon them. Simultaneously, it commands them to do the same in their future actions. As the footwashing continues, the choir and congregation sing from 1 Cor 13:13, where the Apostle Paul preaches of the permanence and superiority of love over all other gifts and virtues. The antiphon from 1 Cor meditates on Paul’s conclusion that among
the most foundational features of the Christian life, the greatest is love.\footnote{Harrington and Keenan, \textit{Paul and Virtue Ethics}, 91–93.} The Apostle’s poignant statement follows his reflection on love’s permanence (1 Cor 13:7) and its unfailing nature (13:8).

It is one thing to state and proclaim these texts from the scriptures. It is another to synchronously embody the evocative images from these sacred texts. The ritual enactment stimulates the imagination of those gathered and forms them to live more fully as Christ’s body alive and active in the world today.

**Holy Thursday—A Hermeneutic for Palliative Care**

I highlight these scriptures and the contemporary liturgical footwashing ritual as a model for how the Christian tradition envisions care for the elderly, the chronically ill, and the dying. It must entail not merely sound medicine and the best clinical practices, but also lavish love.\footnote{By evoking a contemporary liturgical footwashing, I envision the practice adopted by some parishes that washes the feet of all the gathered faithful, or at least all those who would like to come forward and participate in the ritual. See, Jeffery, \textit{“Mandatum Novum Do Vobis,”} 137–141. I have been a part of a parish community that has an established local tradition of preparing for an abundant experience of the footwashing. They situate at least ten chairs around the sanctuary with large basins and several coordinators tending to large jars of warm water and fresh towels. Everyone is invited to come forward to have her or his feet washed. Then, the individual whose feet have just been washed, kneels to wash the feet of the next person in line. It is powerfully moving to see young children washing the feet of their parents or an elderly parishioner. One sees designated ministers assisting those with limited mobility come forward to have their feet washed, and then to whatever degree they are able, they wash, dry, and tend to the feet of another member of the community. This expression of the ritual is not merely emotionally evocative. Rather, such an amplified expression of the rite vividly expresses the need for and power of community. Acquaintances, and in some situations complete strangers, brought together by their Christian faith, engage in such an intimate and loving action as pouring soothingly warm water over one another’s feet and caringly drying them with a towel. Allowing one’s self to participate in this ritual demands vulnerability. The response from the parishioner enacting the washing and drying communicates a sense of unconditional acceptance and care. Even more, when nearly all the gathered faithful engage in this ritual, they embody the action recounted in the gospel. It sparks the Christian imagination to consider how similar actions might be carried out into the daily lives of the worshippers, thereby connecting worship with ethics. They are led to contemplate how this encounter with God’s endless love might now find expression concretely in their own lives beyond.} The Holy Thursday liturgy ritually enacts and embodies what
Benedict XVI might mean by his term “loving care.” The footwashing narrative, for example, can powerfully speak to nurses, physicians, other clinical team member, and even housekeeping—those who routinely wash and flush and cleanse, especially the most vulnerable and intimate part of a patient’s body.

Moreover, we must keep in mind Brown’s admonition that this passage communicates more than just a model of humble service. Like the sacraments themselves, it is polyvalent. It functions like a eucharistic motif, sparking a renegotiation of how men and women might understand illness and death anew. Knowing that he was going to his death, Jesus, as Teacher and Lord, was committed to showing his disciples what it means to love them to death. A death that carries the power to transform the perception of the disciples’ understanding of mortality is also a death that can cleanse medicine of its distorted view of death. His teaching contains two aspects I want to highlight as a conclusion to this brief analysis of the footwashing narrative.

First, Jesus’s love is both individual and communal. Jesus tended individually to each disciple and at the conclusion of chap. 13, he tells them to “love one another” (v. 34–35). Love is manifested in individual acts like that of a footwashing and caregiving. Yet these individual acts can serve ends beyond themselves. They lead to building community. In other words, love has an ecclesiological dimension. 666 Love is the distinguishing mark of the Christian community. The Early Christians expressed their identity in acts of charity particularly to lower social classes and organized institutions.

for the elderly, the orphaned, and the ill.\textsuperscript{667} In many instances, the ill went to live among the Christian community itself. This is not likely to happen \textit{en masse} today, but healthcare in the U.S. is moving toward models of care that must tend to entire communities. The former paradigm of the physician-patient relationship financed by a fee-for-service reimbursement model is changing. Medical reimbursements under the ACA incentivize healthcare systems to manage population health.\textsuperscript{668} In other words, instead of just caring for individual patients, healthcare practitioners must also show concern for populations, or communities of men and women.

Catholic healthcare systems already possess this theological tradition that understands loving care in both an individual and public or communal dimension. These theological insights can and ought to strengthen the system’s efforts to operationalize palliative care for the benefit of the common good as well as the patient’s own good. What I am saying is that palliative care can impact the common good—the community—because its primary driving force is love. So much of palliative care’s scholarship today is based on proving itself on the grounds of quality matrices, standardizations, certifications, and other measured outcomes.\textsuperscript{669} Many such components are important. Patients need and want pain and symptoms to be controlled and minimized, and they want positive experiences of care, most especially when they are suffering and vulnerable.


\textsuperscript{668} David Kindig and Greg Stoddart, “What is Population Health?” \textit{The American Journal of Public Health} 93 no. 3 (March 2003): 380–383. The authors present a standard, although not exclusive definition that identifies population health as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.”

There certainly needs to be mechanisms for accountability. And yet, at the apex of life, the irreparable event of human death, fraught with all its fear and uncertainty, needs love. And “perfect love drives out fear” (1 John 4:18). Palliative care services will flourish when they are committed to both high medical quality as well as to a deliberate connection to living out Jesus Christ’s command to love one another.\textsuperscript{670} In other words the two are not mutually exclusive. The Gospel of John, for example, shows Jesus teaching his closest followers how to be a healing community among a sin sick world.\textsuperscript{671} By washing their feet, Jesus is forming the future church in love, and then he sends them out with the mission to do likewise.

A second way in which the footwashing narrative and ritual moves beyond an example of humble service to provoke a renegotiation of vulnerability and death entails its potential to illuminate meaning for both patients and healthcare practitioners. It is not uncommon for physicians and patients alike to resist palliative care. Such hesitation finds resonance with Peter’s initial resistant response to Jesus’ invitation to wash his feet. Peter gives voice to his feelings of embarrassment at the thought of vulnerably exposing the filth of his feet (13:7–8).\textsuperscript{672} One way to understand Peter’s initial objection is to see it as his misunderstanding of its symbolic importance. In other words, at this point in the gospel story he does not yet grasp the reality and the meaning of Jesus’ death. He has not renegotiated his own sense of death or of Jesus’ ministry of healing the fear and hurts of

\textsuperscript{670} Pairing these two ideas, responsible and accountable medical care along with loving care, was foundational to Dame Saunders and noted by her advisors and biographer (Du Boulay, \textit{Cicely Saunders}, 182).


the world, nor will he fully understand these things until Jesus’ saving-healing actions are finished (John 19:30).

Many men and women when struck by illness and disease find themselves reacting with a disdain similar to that of Peter’s. Often we are more comfortable wanting to do things alone, rejecting the loving support of others to come and help care for us. After learning the news of a diagnosis we want to pursue almost any medical and therapeutic path to heal and save us, even if it entails an unproven experimental drug, a highly invasive surgery, or an uncertain procedure—anything to maintain our sense of independence and to resist the need for someone else to care for us. The perceived shame and the vulnerability of being lifted onto a toilet and needing the loving touch of an aid or a family member to clean the residue of normal, daily, human biological waste, aligns us with Peter retorting “You shall not wash my feet—ever!” (v. 8). The evangelist however, employs the virtues of faith, hope, and love to cut through Peter’s stonewalling retort. Jesus, as love incarnate, first appeals to faith by asking Peter to believe that he in fact will understand the depth and meaning of this gesture, but only later (v. 7). Then, Jesus engages hope that Peter and the others will share a heritage with him (v. 8). All of this demonstrates the depth of Jesus’ love to the very end (vv. 1, 34).

Besides Peter, some patients receiving palliative care services may also understand and renegotiate their experience of physical diminishment and dying through the example of Jesus. Knowing that his own death was before him, Jesus embraced it with grace. An alternative interpretation of Jesus’ command in John 13 could be that like him, we are to view our own human death with the hope that we too are returning to our Divine Parent. Along that journey neither Jesus nor us remain alone. Like Jesus, we can
allow others to join us in the journey. Earlier in the chapter I highlighted Benedict XVI’s comments on palliative care that stressed the importance of loving accompaniment “on the last stretch of earthly existence…toward the embrace of the Heavenly Father.”

Instead of retreating to the isolating confines of autonomy, we can allow others to join us in our experiences of life-limiting illness and remain attentive to the ways in which it unfolds with lavish love.

**Summary**

This chapter began by recounting how Saunders fell in love with two patients. These personal amorous experiences profoundly impacted her dream to create St. Christopher’s hospice house. By examining Benedict XVI’s encyclical *Deus caritas est*, this chapter articulated how romantic love, *eros*, leads to other expressions of love. In particular the chapter argued that agapeic love is inherently ecstatic. Such love that goes outside of itself and beyond the individual context leads to communal expressions of love and ameliorations of the common good. Through Benedict XVI’s two encyclicals, I explored love as gratuitous gift from God that has the power to transform individually, communally, and politically. The pontiff’s theological reflections on love correlate to his insight on palliative care as loving care. Moreover, I used his vision that love grounded in the practical forms of the common good and justice to argue that a conscious retrieval and application of love can transform palliative care not only at the bedside, but also and especially, in the systemic and political structures that confine and enable it.

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673 Benedict XVI, Health Pastoral Care.
Finally, I suggested that scripture and ritual continue to form the worshipping community today in the pattern of Jesus’ love. Today, palliative care practitioners from physicians and nurses to social workers and chaplains can demonstrate basic baseline competencies and knowledge to receive a certification in their discipline, but this does not substitute for the formation of heart that is necessary to surround the chronically ill and dying with love. The sacramental-liturgical life of the church prompts the renegotiation of health, wellness, and death for all who participate in palliative care—patients, family members, communities of faith, healthcare practitioners, administrators, and the governing and sponsoring bodies for health systems. Christian communities and Catholic healthcare systems that enact the loving, healing mission of that community, hold the powerful potential to transform aspects of U.S. health practices. They can promote palliative care as a more widely used and accepted medical practice that can impact not only individual patients but also the common good.
Final Thoughts

I have little doubt that a primary issue that will mark the twenty-first century is how we die and how we allow technology to influence the management of our disease progression and the journey toward death. To meet the social and religious facets of sickness and death, Catholic healthcare ministries need to champion a preferential practice of palliative care. In this work I have offered a theological framework in which healthcare systems can discern more clearly how their Catholic identity can influence the more particular implementation of a palliative care program. The theological foundations for models of loving care for the elderly, the vulnerably ill, and those with chronic and terminal illness create a rich environment to provide a more distinguished alternative from medicalized dying. Without some alternative narrative the essence of technology will singularly stand as the pathway for all patients, complete with all its benefit and its many limitations.

A preferential practice of palliative care means that all levels of a healthcare system will create an environment and sustain sound medical practices that promote the flourishing of palliative care in much the same way that Dame Cicely Saunders established a place where patients were unencumbered by the burdens and oppression of medicalized dying. Establishing such an environment within Catholic healthcare can only happen if first, medical and administrative leaders rigorously and honestly identify the powerful structures and the epistemologies operative with the U.S. healthcare system. Then, discernment is needed to reflect upon the congruency of these forces with the richness of the theological tradition. Identifying the points of disconnection then guides a process to consider the necessary changes to better align the practice of palliative care
with the Catholic faith. Support will be necessary at every level—from the sponsorship board and board of directors to hospital executives, physician leaders and medical staff, nursing leaders, and heads of departments. What is more, my argument that palliative care in a Catholic context also involves a sacramental locus, necessarily entails parish clergy and diocesan leadership. This means that to concretely move toward a preferential practice of palliative care, significant efforts will be necessary on two different fronts: within healthcare and within local parishes. The healing ministry of the church needs to work with the catechetical and sacramental ministries of the church, and vice versa. In conclusion, I offer some considerations for Catholic healthcare systems and parishes.

Suggestions for Healthcare Practitioners

Within the clinical realm I offer three broad points of consideration. First, Catholic healthcare systems need to engage a process of reflection on the essence of technology and acknowledge the organization’s complicity with it, including the violence and structures of sin produced by technology. Catholic healthcare stands out as a model for decision-making processes guided by discernment. It must use these discernment models to chart not only an appropriate but a virtuous use technology. This is particularly needed for the organization’s strategic plans concerning palliative care. In other words, Catholic healthcare needs to sustain an ongoing dialogue on the intersection of faith and technology. Healthcare is the very laboratory where these two forces meet. Catholic healthcare already has formation programs that emphasize Catholic social

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teaching. What is needed is further reflection on what the tradition teaches about
technology and what the implications could mean for healthcare ministries. The dialogue
would contribute a critique from the point of faith on healthcare’s reliance on technology.
Such a critique would serve to further the Catholic tradition’s engagement of faith and
technology, or more broadly, faith and reason.

Second, Catholic healthcare must engage its physicians. It must support and
promote physicians who demonstrate a preferential practice of palliative care. At a
minimum, this means that the physician follows nationally recommended guidelines for
patient care that calls for palliative care consultation at the time of diagnosis for certain
conditions. Physicians ought to demonstrate a willingness to collaborate closely with
palliative care specialists, as well as integrate aspects of palliative care within their own
practice.

Many Catholic healthcare systems have customized formation for physicians.
Such formation must include palliative care and its deep roots in the sacramental and
liturgical traditions. In addition formation ought to include thorough discussions on the
paschal mystery. Catholic healthcare systems may even want to explore formation
models based on the patterns of the liturgical cycle. The flow of the liturgical seasons is
a perpetually pulsating part of the lives and spirituality of women religious. Today, apart
from an advent wreath, a Christmas tree, and a crèche in the hospital lobby, it has no
discernable bearing on Catholic healthcare. The formation programs can be the place
where dialogue regarding faith in the paschal mystery and technology can continue
among the very people who employ medical technology, see its benefits as well as
experience its failures. A focus on the paschal mystery throughout the liturgical season
would communicate to those in Catholic healthcare that the clinical pathways and medicine dosing protocols are not the only and surely not the primary markers of time. Placing the rhythms of the liturgical cycle at the heart of Catholic healthcare would allow for a fresh perspective of life, death, and new life to emerge for healthcare practitioners and those they serve.

A preferential practice of palliative medicine means that physicians will be clear with patients when a therapy will be temporary and when interventions will not ultimately keep them from dying, such as in the situation of chronic illness. They will need to reiterate this multiple times to the same patient and share with them that there will be ups and downs, but the overall trajectory is toward death. Some physicians have found that showing patients a graphed visual depiction of chronic illness can be helpful. Stated differently, physicians in Catholic healthcare institutions need to have a commitment to tearing down the illusion that medical technologies will permanently solve the patient’s ailments.

Another tool to help physicians engage a preferential practice of palliative care, as I alluded in Chapter Two, is to enable them to discuss matters of faith and spirituality with their patients. While my work has focused narrowly on the Catholic tradition, every faith tradition possesses some manner of understanding human mortality and the afterlife. Physicians and other members of the care team need the skills to comfortably and competently ask patients about their faith lives and religious practices. A follow-up question could be, “How does your faith impact your understanding of your current health situation?” or “What does your tradition say about death?” Such questions invite

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the opportunity for the patient to engage in theological reflection. Typically, in the last several decades, chaplains have initiated the conversations. However, it is a mistake to sequester a patient’s faith life to this one role.

One final point regarding physicians, and to that I would add advanced care practitioners, Catholic healthcare ought to promote physician leaders who practice a religious tradition and foster a living faith. I have argued that the Catholic sacramental-liturgical practices are especially attuned to the aims of palliative care and enable it to avoid the undesired aspects of medicalized dying. Promoting leaders whose lives, beliefs, and values are congruent with the organization’s mission and values will better enable the success of palliative care. Formation programs are one place where Catholic physicians, for example, can share and learn how their own practice of faith can support their medical practice. This also applies to other-than-Catholic physicians. Research by Farr Curlin, M.D., shows that it is a mistake to view physicians as purely objective practitioners of scientific medicine. Rather, their own personal beliefs and religious practices influence their practice of medicine. Leaders in Catholic healthcare ought to capitalize on this reality and support those physicians who can best support a preferential practice of palliative care. The proposed alignment of physician beliefs with the organization’s aims need not be limited to Catholic and Christian physicians. For example, like the

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early Christians, early Muslims also viewed caring for the sick as a religious duty. Leaders in Catholic healthcare need to explore the religious traditions among their practitioners. Mission leaders and ethicists, for example, need to know what the various world religions believe and teach regarding human finitude and the afterlife. This is increasingly important given the pluralism in American society and among the internationally and religiously diverse physician pool. Through formation or other mechanisms of dialogue and reflection, Catholic healthcare leaders can engage in reflection and dialogue on those components of various religious traditions that support or hinder the flourishing of palliative care.

The third and final practical suggestion in the area of healthcare pertains to Eucharist. In order for Catholic healthcare to support a preferential practice of palliative care it must speak of its eucharistic roots. Leaders in Catholic healthcare ministries, from sponsors, to board members, and executives, must not be afraid to contend with the eucharistic sources of its healing ministry. There is a clear sense that Eucharist presents a volatile and contentious subject within Catholic healthcare. Some of the difficulty in discussing the connections between Eucharist and healing lies in the fact that much of Catholic healthcare is enacted and even led by men and women who are not Catholic. A closed Eucharist in the Catholic tradition further compounds the situation. Thus, there is the sense that leaders, including ethicists and theologians within Catholic healthcare, ought not to raise the issue because to do so would mean that significant groups of people within the healthcare ministry would be excluded. Without denying the difficulties involved, I want to raise three points.

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678 Siebold, *The Hospice Movement*, 16.
First, there are overt connections between Eucharist and the early Christians as well as the lives of the women religious who founded, led, administered, and governed these large institutions across the U.S. It should be taken as a given that the care that distinguished the women religious necessarily involved a eucharistic component. As Catholic healthcare leaders retell the heritage of their founders, they need to highlight the connection to the sacramental-liturgical life of the Church. The problem today is that the importance and influence of the Eucharist is much more opaque with the influx of lay leadership in Catholic healthcare ministry. Second, Catholic teaching precludes non-Catholics from receiving communion in most circumstances. It neither excludes non-Catholics from participating in all other aspects of the Catholic eucharistic liturgy, nor does it prevent them from fostering a eucharistic spirituality. The participation of non-Catholics at the Catholic eucharistic liturgy may become the very reason for admitting them to communion in the future. The rush to emphasize how much everyone is the same and to reduce the richness of the Catholic tradition to a handful of universal values, too easily glosses over important differences—differences that may enrich us rather than diminish us. Third and lastly, by avoiding, or even refusing to reflect on the eucharistic connections with healthcare ministry, we sacrifice an essential element of our Catholic identity. It cannot be denied that Eucharist has always been the crowning sacrament of the believer’s Christian identity. What is needed in future work is a eucharistic theology

679 Today, nearly every Catholic parish in the U.S. has non-Catholic spouses and loved ones attending Catholic Mass with the rest of the family. Non-Catholic spouses, for example, have been known to serve as ministers of hospitality or sing the choir.

680 The Rite of Christian Initiation states that “no greater burden than necessary (see Acts 15:28)” is needed to allow validly baptized Christians to come into full communion with the Catholic Church (RCIA, in The Rites, § 473). See also, Paul Turner, When Other Christians Become Catholic (Collegeville, MN: Liturgical Press, 2007).

It must also be noted that there are exceptions to the Catholic teaching on closed communion. See, Pontifical Council for Promoting Christian Unity, Directory for the Application of Principles and Norms on Ecumenism, 25 March 1993, §129–131.
for Catholic healthcare. By more clearly grounding palliative care, and Catholic healthcare more generally, in the Eucharist, Catholic healthcare systems may experience stronger ties with ecclesial authorities. Eucharist is the sacrament of unity. As noted in this work, Vatican II articulated the Sunday celebration of the Eucharist as the “source and summit” of Christian life. Eucharist has been described as the very life of the world, the Sacrament of the Kingdom, the Cosmic Mass, Food for the Journey, and many other images relevant to healthcare.

**Suggestions for Local Parishes**

Raising the subject of Eucharist and the sacramental-liturgical practices of the church necessarily entails the involvement of local parishes where the rituals occur. Three groups of people within a local parish can work together to pursue a preferential practice of palliative care. The three groups are the ordained clergy, members of the parish pastoral staff, and individual parishioners including healthcare professionals within the parish. The aim would be to bolster a theologically informed understanding of palliative care among faith-practicing healthcare professionals and especially for parishioners, many of whom will one day need palliative care.

First, much can be done through the role of the ordained clergy. This includes the local bishop, pastors, priests, and deacons, as leaders and preachers. Beyond the suggestions previously made in Chapter Three, preachers need to explicitly and routinely make the paschal mystery the center of their preaching. They need to connect the

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liturgical seasons and particular ritual celebrations, like the footwashing narrative, to the very lives of the people in the pews. The Lenten journey and Easter resurrection are prime opportunities to concretely reflect upon the Christian understanding of death and a hope that transcends the promises of technology and contemporary society. Similarly, Advent poses a unique richness to explore themes such as the long waiting often involved in a loved one’s journey through chronic illness and death. The eschatological anticipation of peace and justice that marks this season speaks empathetically to those who long endure great suffering and await the in-breaking of divine grace. Ordinary time gives the opportunity to preach about human sickness, how common it is, and how the celebration of the Eucharist is intended to help believers bear their hardships like Christ, and not necessarily cure us or take away the painful struggle.

Relatedly, the denial of death prevalent in medicine and society could be persistently unmasked and challenged if pastors and preachers would be resolute in preaching the theology of *Rite of Funerals* and refuse to turn the funeral liturgy into a “celebration of life” for the descendant. Here again, such occasions present opportune times to seriously contend with the inevitable reality of human death, but to do so within a context and narrative informed by the Gospels, the Christian baptismal identity, and most especially, the paschal mystery. Many parishes have experienced success in areas similar to these suggested by giving particular attention to parish liturgical formation. These suggestions imply that priests and deacons need continuing

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683 See Christopher Vogt’s reflections on the Christian virtue of patience in the midst of dying in *Patience, Compassion, Hope, and the Christian Art of Dying Well*.
education, formation, and resources pertaining to these themes. Their own formation could spawn the deepening of faith for their pastoral staff and parish.

Fostering a preferential option of palliative care among the Christian faithful will also need the involvement of leaders of faith formation teams and catechists. These parish leaders need to make the paschal mystery more central in their formation materials. They can help parishioners of all ages reflect theologically on how the sacramental life of the church relates to our individual and family experiences, including our experiences of illness, vulnerability, and death. This will become increasingly important as the Baby Boom generation begins to reach the age where chronic illness and health complications become more apparent in society and in our parish communities.

Third, individual believers are challenged to more consciously allow their own faith in the paschal mystery of Christ Jesus to play an integral role in their lives. More specifically, with the help of preaching and formation opportunities at the parish level, individual parishioners can grow and learn to apply their faith to their discernment of medical options when they confront chronic and terminal illnesses and the hour of their death. These suggestions begin to present a rough sketch of what a parish formation program on health and palliative care might look like. As Christopher Vogt suggested, one well-established and successful model is the RCIA. It involves priests and preachers, pastoral leaders and catechists, parishioners serving as sponsors, and parishioners preparing to fully participate in the sacramental-liturgical life of the church.

Every parish community has healthcare professionals. They too may be strengthened by the sacramental-liturgical rituals, just as Dame Saunders was. This is especially true and necessary for those who care for the elderly and the chronically and
terminally ill. In Chapters Two and Three I noted how some aspects of liturgical and sacramental ritual could inform the practice of medicine and care for these individuals. Moreover, parish formation programs could specifically tailor outreach to this population in the parish. For example, a pastoral leader could invite a group of healthcare professionals to form a scripture study group. They may spend a season or several weeks committed to reading the Sunday scriptures. Together, they would engage in theologically reflecting on how the scriptures speak to their work and their own lives. How does their faith and participation in the Sunday Eucharist give them refreshment from the many burdens laid upon them from their work? How does it give them hope, and how might it help them to more fully love those for whom they care?

These suggestions presume the need for written materials. To this point, I have two suggestions. First, parishes should consider forming a Parish Health Advisory Committee. This would comprise of parishioners who are healthcare professionals, such as physicians, advanced care practitioners, social workers, nurses, therapists, phlebotomists and medical assistants, healthcare administrators, and even professionals in health information technology—virtually anyone who works in healthcare. A key task for such a parish ministry would be to identify ways to keep a holistic understanding of health a focus of the parish ministries. Moreover, such a group could sustain an ongoing theological reflection on the nature of faith and technology. This can help to inform the clergy on topics of importance for purposes of preaching and assist pastoral leaders in identifying topics for formation.

A second suggestion to address the need for formation materials involves Catholic healthcare ministry. The Catholic Health Association and individual Catholic healthcare
systems possess the resources and the theological expertise to produce materials that could be of use to parishes. Catholic healthcare leaders, specifically mission leaders and ethicists, may want to consider partnering with parishes closest to their local hospitals. In addition to providing quality training and formation for those who take communion to the sick and hospitalized, these highly trained persons in the fields the Catholic tradition and healthcare could help develop materials for parish formation programs. A benefit could be that parishioners who partake of such formation programs may one day be future patients who could be more familiar with and attuned to concepts like palliative care.

At a time when it seems that communities of faith are struggling to assert their relevance to a skeptical society, I believe that communities of faith can reestablish trust and integrity living out the grand narratives that sustain these traditions. A central motif of the gospels is to care for the sick. The Christian community must not envision this to be solely the work of professionalized healthcare. Local parishes provide necessary components for the healing of a sin-sick people and world. Together the prayer of the church and the church’s healing ministry of care can work to reignite the longing shared by Christians and other people of faith and good will to participate in extending loving care to one’s neighbors and most especially to the elderly, to those with chronic conditions, and to the dying.
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