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The Moral and Pastoral Problems of the Terminally Ill Patient

C. Harvey Lord

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In reviewing our findings, it became apparent that the yield of abnormalities was quite high. As was expected, most of the pathology was found in the older age group of nuns. In the initial study of a group of 120 nuns examined, a 10 percent evidence of anemia was found, particularly of the iron deficiency type. The majority of these nuns were in the younger age group with active menstrual cycles. In the same group of 120, six abnormal postprandial blood sugars were detected. Two of these proved to be known diabetics; the remaining four were unknown.

Two primary carcinomas of the breast were found, and one of these two nuns also had a primary carcinoma of the vulva. One Pap smear was reported as positive; however, further follow-up ruled out cervical malignancy. One routine chest x-ray revealed bilateral hilar adenopathy suggestive of a lymphoma. Two unknown cases of mitral valve disease were diagnosed for the first time. The incidence of hypertension was quite high, especially in the older obese nuns.

Numerous other diagnoses were made, including endometriosis, cervical erosion, cystic mastitis, various arthritides, including gout.

At the conclusion of the examination, each nun was interviewed and the findings were discussed and explained. Those with any pathology were advised to see their own physicians. Those without personal physicians were advised to obtain one. In certain instances, x-ray screening of the GI tract was advised.

Problems of follow-up have become quite apparent.
to you because the knowledge is scientific and can be most accurately relayed by one who knows the exact nature of it.

The answer to the question, "How much truth should be told?" cannot be given abstractly. In each case a separate judgment must be made, similar to that made by the surgeon when he judges whether or not a patient can undergo surgery. In this case, it will not be a decision of whether the organism has the capacity for surgery without entering shock, but of whether a personality has the resources to know truth without psychic shock.

Some people live honest courageous lives. They regularly face difficulties squarely. They approach death with spiritual resources, and they want to know the truth so that they can be as intelligent and as responsible as possible in their last days or hours. Such a person may look you squarely in the eye, and ask rather frankly about his condition, and you will be able to answer frankly.

Other persons simply cannot face the truth. They live in a society where all that is related to death is removed from ordinary life. "Living" goes on in homes, shops, stores. "Dying" is separated from these places, and goes on in isolated compartments, like hospital rooms. Even there, additional curtains are drawn, and doors are closed as death approaches. We depend upon funeral directors to give the lie to death with mortal remains which appear not to be dead at all. Although you may be committed not to encouraging anyone in such an unreal approach to life's limits, you cannot on the other hand hope to shock them into becoming totally different persons with one startling announcement of their own approaching demise.

Tell them gently as much as you think they can endure. They sometimes are aware of their own limits and hesitate to ask what they fear to learn.

You have one further obligation in telling the truth to your patient. You must not simply tell it; you must communicate it. This means that you must move the meaning from your mind to his so that when it arrives it looks something like it did when it left your brain.

I would compare some priests I have served to a man walking round with a dozen pigeons perched on his shoulders and head, all ready to take flight at the slightest provocation. Each pigeon represents a "self uncontrolled thought about health." You report on his health inadvertently use a medical term he doesn't understand. These pigeons go aloft. You make some remark about a consultation, and there more birds fan the air. It doesn't take much to get all twelve flying at once.

You may need to ask the patient to relate back to you what you have told him about his illness to discover the distortions that have already taken place. If you have time, probe his psyche a bit: "Do your symptoms cause you to have anxiety about any particular illness?"

I take seriously what a patient tells me about his illness. I do not consider that it is the final scientific analysis, but it does represent either how he understands his own illness or else what he wants me to know about it. Under ordinary circumstances, I consider this partial know-

edge advantageous. My interest is not in the science, but in the patient's understanding of himself and his predicament. The exceptions are when the person is scheduled for surgery, or is critically ill. In these instances, some member of the family should so inform the clergyman.

TYPES OF NON-SCIENTIFIC MINISTRIES

Other problem areas of the terminally ill are best understood if one approaches them by considering four kinds of non-scientific ministry. I term them non-scientific since the kind of knowledge which comes from carefully controlled experiments yields little light for them. They could also be called "personal ministries." I separate them into confessional, affectional, ritual and meaningful.

The confessional ministry is not simply that of letting a dying person confess some horrible sin. Many persons have no such horrible guilt upon their conscience, and it becomes a sort of manipulation to make them produce one! Nevertheless, there is nothing more private than the inner thoughts of each individual. Hidden thoughts yearn for sharing if the circumstance arrives where it is safe to share. Many people have something they want to talk over with someone before time runs out.

The confessional ministry could be called the ministry of sensitive listening. The clergyman is ordinarily thought of as the ideal recipient of such confessions, but they may be given to anyone who gains the deep trust of the critically ill. You as a doctor may receive such confessions of hopes unfilled, of shame unsoiled, of mystery unsolved, of timidly unexpressed. For that moment you become a holy minister offering a holy service to a person whose confidence you are bound to respect.

The affectional ministry is asked for by the patient when he requests that his spouse "just sit in the same room." We die one by one, and it is natural to ask for assurances of love and evidences of concern. This is sometimes what the patient really requests when he asks, "Can I go home?" Home may not be sanitary, but the sound of familiar voices, the ministrations of one's own family, and even familiar pictures on one's own bedroom wall have sustaining power.

I do not argue for home or hospital as if one were blessed and the other condemned. I urge when possible, opportunity for an affectional ministry, not only brought indirectly by a postman who delivers cards, or the florist with the plant, but the presence of relatives beside the bed, and the visit of old friends. When a patient tells his doctor radiantl, "My pastor called today!" he may not only refer to the religious solace thus received, but also to the fact that the pastor represents the care, prayer, and concern of an entire congregation. His presence in the room says, "To us, (meaning the congregation) you are very valuable."

Doctors perform affectional ministries. You know that sometimes a point is passed where medical strategies mean little. Yet you go in and chat with the patient. Such visits may "take more out of you" than diagnosing and prescribing. They are a genuine service.
By ritual ministry, I refer to the various kinds of religious services which rabbi, priests, and pastors bring to the ill: our prayers, Bible readings, communion, and anointing. A meaningful ritual is an oft-repeated practice that speaks in a poetic symbolic way of a genuine power discovered and known in the midst of life. Protestant, Catholic, and Jewish ritual express the faith that this unseen Power makes life rich and valuable despite threats of every kind.

Persons who may be unable to bring themselves to speak of the seriousness of their condition, can partake of a ritual which admits finitude but sets over against it a larger trust. Frequently, the only reference to death I make during a visit is by means of the scriptures read or the prayers offered. Persons who cannot find words to speak of their fear are enabled to overcome it with the help of ritual.

Ritual help in crisis is most available and helpful to those who have used it often before. It is received according to a particular tradition. Critically ill persons want "their pastor," "their priest," or "their rabbi" and they want him to use the accustomed service forms.

Finally, there is the ministry of meaning. To a surgeon, each operation may be somewhat like others of the same grouping. But to the patient, his operation is a uniquely meaningful experience. And the possibilities of the meaning of a single operation range on a wide continuum, from tedium to excitement, and from dread to secret delight.

Even so, the experience of dying is capable of multiple meanings. It may be one of the great and high moments of living. If a person really desires to drink life fully, and to live it richly, he may wish not only to know the moment of birth, of falling in love, of true friendship, of head-fastness under attack, of competing an important assignment, but also, and perhaps most of all, to know those final, finishing moments called dying.

For those of us in the Christian faith, the very symbol of the cross reminds us of the possibility that the moment of death may be experienced with tranquility and triumph. The clergyman may offer a meaning to the experience of dying which makes possible heroism and courage born of faith. It stands as a mark against us that many persons prefer not to "die" (to live through the final experiences consciously, knowingly, and trustingly) but to "cope out." Man, who alone has capacity among God's creatures to be alert to his own future, also has the capacity to descend with help of drugs and sedatives to the level where the future approaches darkly and unseen. Many persons so depart.

Yet where any individual struggles heroically (with full knowledge of his predicament) either to survive (whether or not successful) or with resignation to approach death serenely, we witness a moral power that has potential to enrich the experience of many others. It is sorely needed in our virtue-timid age.

These are central problems and central ministries to the terminally ill. The ministries of confession and affection you physicians frequently perform. Those of ritual and meaning are largely our duty. You can assist us in the latter by never simply precluding the possibility that this patient may be the very one who has the religious faith requisite to enable him to die with a dignity possible only for faithful men. Be alert for that one who can accept the termination of his bodily strength, culminate his responsibilities with care, bid a conscious farewell with attendant blessings to his close associates, and lay down his life even as God requires it of him. Hide from him no fact. Offer him no crutch.

REVEREND C. HARVEY LORD is the pastor of the Morgan Park Christian Church in Chicago and has his Ph.D. from the University of Chicago Divinity School.