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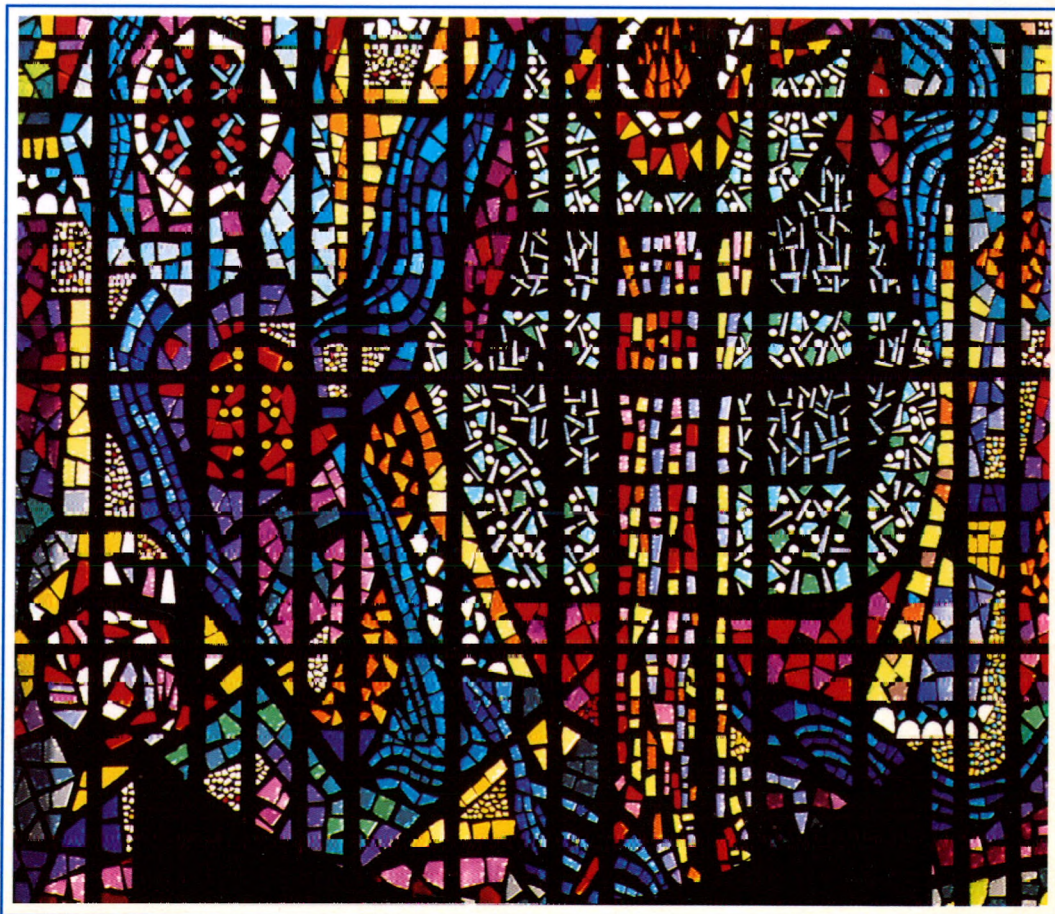
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Second Opinion

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health, faith, and ethics



The Church's
Challenge in
Health Care

C. Everett Koop • James Mason • Rosalynn Carter • William Foege • Jimmy Carter

Cover:

Chapel window, south facade, Cenacle Retreat
House, Chicago, by Adolfas Valeska, 1967.

An abstract presentation of the fundamentals of Christian doctrine. The Blessed Trinity (three multicolored globes on the left) is united by seven blue rivers (the Seven Sacraments) with the Tree of Life on the right (its three horizontal branches represent faith, hope, and charity and are topped with a huge blossom, symbol of divine love).

LUTHERAN GENERAL HOSPITAL
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Second Opinion

health, faith, and ethics



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Second Opinion, as its name implies, recognizes that the complexities of modern health care make it increasingly difficult to find the single “correct” action, thought, or method. Each situation is open to a variety of apparently legitimate and appropriate interpretations and applications. But such confrontations with ambiguity need not lead to discouragement. They can instead elicit greater research, discussion, and thought.

By inviting contributions from a wide range of perspectives, *Second Opinion* stimulates interdisciplinary conversations between members of fields relating to health, faith, and ethics. While other publications deal with one or two of these concerns, *Second Opinion* distinctively seeks to address all three. The Park Ridge Center created this publication in the hope that it will help form one public out of a number of related constituencies. This public will not only wish to relate ethics and faith to health issues, but should also, through lively and enlightened interchange, be better equipped to do so.

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Initial Comment

Free Spaces

On the evening news these days images of unsettling events in Rumania and the Azerbaijan region of the Soviet Union have replaced more hopeful ones of the opening of the Berlin Wall and the formation of new democratic governments in Poland and Czechoslovakia. Before those epochal events of the last months of 1989 disappear completely into the netherworld of yesterday's news, it is important to replay some of the action and freeze a frame or two of the recent Eastern European story in our memories. Linger for a moment in front of St. Nicholas Church and St. Thomas Church, both in Leipzig, East Germany. These two churches, along with many others throughout Eastern Europe, played important behind-the-scenes roles in stories that made us spend more time than usual with our newspapers. The churches of Eastern Europe did not invent the popular movements that swept across Eastern Europe as we watched. By and large their clergy were not the front-line leaders who captured the imagination of the world. For that reason only a few journalists bothered to call our attention to these institutions, which over the past half-century have been on hard times, at best.

Yet these churches made a critical difference. In East Germany and elsewhere, they provided indispensable "free spaces" where people could come together for a kind of conversation that could take place nowhere else. Within the churches a discourse took shape which over the years helped to open new possibilities for Eastern Europe. Home, factory, university, and government could not nurture open

talk about a better future. But the churches made room for words about democracy and change to be spoken and heard.

Why comment upon this unexpected role of the churches in a journal devoted to health, faith, and ethics? Certainly the events of late 1989 were directly related to such themes. The faith of these frustrated people; their passion for a way of life that fosters human flourishing; and their decision to set aside certain norms in favor of others undoubtedly have many contact points with the normal contents of this publication.

But there is a simpler reason for this brief venture into current events. Societies on both sides of the now obsolete Iron Curtain have need for free spaces. When they are provided, new possibilities can emerge. But sometimes we have to go halfway around the world to see our situation more clearly.

This issue of *Second Opinion* demonstrates the "free space" phenomenon as it occurs closer to home, on American soil. In two very different settings rare kinds of conversation became possible. The first half of this issue shares the actual conversation that took place at an unprecedented conference cosponsored by the Carter Center of Atlanta, Georgia, and the Wheat Ridge Foundation of Chicago, Illinois. Since the Carter Center's opening in 1986 it has attempted, without using the phrase, to provide free space for off-the-record political conversations to occur, with the aim of helping end long-standing civil conflict in nations around the world. Recently we have witnessed its efforts to mediate between contending parties in

the twenty-eight-year-old civil war in Ethiopia. Creating free space for such conversations is central to the Carter Center's self-understanding.

The papers we publish here are on a very different topic: the role of the churches in American health. But the Carter Center's approach remained the same. Working together with American public health officials and religious leaders, the center created a wide-ranging conversation about the public health challenge facing our religious communities. The group met to talk, to listen, to consider options and responsibilities. Unlike most American political discourse this conversation was not fettered by parliamentary maneuvering or the tallying of interest group votes. Rather than rushing to resolutions the conference paused to consider one aspect after another of a multifaceted and long-term societal health agenda. More amazing still was the unusual mix of participants. Political leaders, denominational representatives, front-line public health officials, and social ministry personnel spoke to each other as equals. And, as you will see in this collection of speeches, unusual things began to happen. Public health officials like former Surgeon General C. Everett Koop and Assistant Secretary for Health James Mason and political leaders like Jimmy Carter and Rosalynn Carter did not just talk *to* religious leaders. Instead they talked about the great health needs of our nation and world and then talked about religion's responsibilities for them. They dared to go even further: they appealed to the nation's religious communities for help with the public health problems now facing us. In essence, the free space of the conference had created a momentary opening in the "wall" of separation between church and state. This unofficial gathering made possible a much needed conversation which our conventional settings do not encourage.

Further, this conference, although addressed primarily to the churches, sought out representatives of other nonchurch religious communities so that a remarkable religious interchange also occurred.

The second half of this issue shifts attention from large-scale concerns—the national health challenge to our religious communities—to small-scale ones. Here we consider the results of one congregation's attempts to create a "free space" in its midst. Again the free-space phenomenon has consequences. A person with chronic illness, a neurosurgeon, and a professor of nursing share the results of Grace Lutheran Church's experiment with a new religious and moral discourse.

Regular readers of *Second Opinion* will quickly notice that both halves of this issue feature different kinds of articles from those usually found in these pages. We made this shift because the Carter Center and the Wheat Ridge Foundation generously offered these speeches to *Second Opinion* and because we believe a larger audience needs to participate in the conversation they began. Our next issues, however, will return to more customary fare: for example, articles by Daniel Callahan and Melvin Kimble on aging, Mark Weitzman's consideration of the ethics of using Nazi medical data, and interviews with noted author Norman Cousins and ethicist James Gustafson. We will also begin a new series of clinical case narratives; we hope through them to create another free space for people to talk about important topics in settings that make possible new perspectives and partnerships. We hope that time spent in *Second Opinion's* free spaces will encourage readers to find or invent a few of their own.

J. P. W.

James P. Wind



Left to right: Former president Jimmy Carter; C. Everett Koop, former Surgeon General; Reed Tuckson, Commissioner of Health, District of Columbia; William Foege, executive director of the Carter Center; James Mason, Assistant Secretary for Health; and former first lady Rosalynn Carter.



Striving for Fullness of Life: The Church's Challenge in Health

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William H. Foege and Constance C. Conrad of the Carter Center with Robert J. L. Zimmer and Phyllis N. Kersten of the Wheat Ridge Foundation were instrumental in planning and coordinating the conference. Karen Weaver of the Carter Center helped make possible the timely production of this volume. The above logo was created by Wayne Kosterman of the Identity Center for the Carter Center-Wheat Ridge Foundation conference.



Health Care in the U.S.

The Social Issues

C. Everett Koop



A huge gap exists between the dream of ideal health care in the United States and the reality of its availability. Our aspirations far outdistance the resources available to pay for them. In the circles in which I travel, conversations on this subject are constant. I hear them among doctors and patients, nurses and therapists, social workers and pharmacists, representatives of big business and small business, members of Congress, the elderly and the young. It isn't so much that things are changing as that things have changed, but many people are trying to plan the future as though it were indeed yesteryear. Several current realities need to be faced squarely if our planning is to be intelligent.

First, the doctor-patient relationship has deteriorated significantly over the past two decades. This deterioration began, I believe, when professionals in the delivery of medical care—doctors, nurses, therapists, and so on—started to accept the nomenclature of providers. Their patients in turn slipped several cogs when they permitted themselves to be called consumers. People aren't happy about being ill or needing to go to a physician. Having to pay a high price for a physician's care increases people's dissatisfaction. But we need to subordinate the economic aspect of the relationship to

the climate of trust between doctors and patient. If patients think of themselves primarily as consumers, getting the most for their money, they automatically put the doctor in the role of the seller, getting the most for his or her services. Furthermore, the mobility of American society and the increased use made by urban folks of hospital emergency rooms as their primary physician are simply not conducive to positive relationships between doctor and patient.

Second, the gap between our aspirations and our resources has opened at the worst possible time, a time when demographic trends are running against us. Today, for example, for each person over the age of sixty-five, there are *five* younger tax-paying wage-earners to pay for that one person's Medicare coverage. In another twenty years, however, for each person over the age of sixty-five, only *three* younger tax-paying wage-earners will be contributing to Medicare. In a climate of scarcity, Americans will have to work out an equitable sharing of needed medical resources between one population that is growing—that is, those over the age of sixty-five—and the population that is shrinking by comparison—that is, those under the age of eighteen. Over the past eight years I've dealt with advocates for children and advocates for the elderly—both very dedicated and persuasive groups. And both quite rightly will be competing for a *larger* piece of a *smaller* pie.

Third, the American family has changed, and these changes are now rather solidly set in society. A stereotype of the American family held not so long ago—the

father at work, the mother at home spending her life taking care of 2.2 children, her husband, and her house—is now met by only 10 percent of families. Families today are smaller. We have more single-parent families, and we find a greater variety of living arrangements. Mothers are out of the home; six of ten mothers with preschool-age children are in the labor force, two-thirds for economic reasons. Individual members of families are older than they were a generation ago. Alcohol and drugs are abused by more family members. More teenagers are becoming mothers. Because families are smaller, and because more elderly people are dependent upon families, the responsibility for such care falls on fewer children for longer periods of time.

It is my firm belief that all of the above factors contribute in some way to violence. Of course, risk factors in abusive families vary considerably, and I do not mean that most families have all or even most of these characteristics. But there is a pattern. Abusive families tend to become isolated; the men are prone to alcoholism, economically depressed, and frequently unemployed. Discouraged men become concerned about power and the regaining of lost status, and frequently their abusive behavior at home is carried into society at large.

Another change in the management of the public's health, made before I came into the federal government, was the closing of many mental institutions with the expectation that communities would absorb the inmates in halfway houses and sheltered workshops. But those inmates have not been sheltered and protected, and

If patients think of themselves primarily as consumers, getting the most for their money, they automatically put the doctor in the role of the seller, getting the most for his or her services.

today they form a large segment of the homeless in America. (Americans, it may be observed, are generous to a fault, but they do not like AIDS hospices, drug abuse treatment centers, homes for the retarded, or shelters for the mentally ill in their neighborhoods.)

Another change has been the closing of the great city hospitals in this country. But these are desperately needed now to care for the indigent, the homeless, and now the burgeoning number of AIDS patients, who frequently are also either indigent or homeless.

The health care system in America today does not respond at all to some 12 to 15 percent of our population. This fact constitutes a terrible moral burden. And because that same system satisfies its own uncontrolled needs at the expense of every other sector of American society, it creates a terrible economic burden for society as well. We need to change that system. We need to change it thoroughly, and we need to do it soon.

Some critics attribute the economic crunch chiefly to the budget deficit. Once we get rid of the deficit, they say, we will also close that gap between aspirations and resources—between dreams and reality. *Before* we had a budget problem, however, we had a health care economy whose annual inflation rate was two to three times the inflation rate for the rest of the American economy. We didn't see it, or if we saw it, we preferred not to worry about it. Today, we still have an inflated health care economy, but we also have inflated health care aspirations. And we simply can't afford any inflation at all.

Some will counter that things really aren't that bad: they suggest remedies like putting a reimbursement cap on *this*, changing the eligibility regulations for *that*, cutting back a little *here*, or pruning a little *there*. During eight years as your Surgeon General, I thought about the true human costs associated with such a patchwork approach, and today I'm more convinced than ever that our whole health care system needs some major corrections. Critics will say, "Wait a minute, Dr. Koop. The system ain't broke, so don't fix it."

But I have to reply, "You're wrong. The system *is* broken . . . and it *must be* fixed." Band-Aids won't do. Hospital costs are still climbing, and no one can prove to the American people that the quality of hospital-based care is uniformly going up as well. On the contrary, our people complain that they are paying more and more for medical care while getting less and less. Worse still, as the cost of hospital-based care increases, the hospitals themselves are trying to narrow their patient pool—for example, eliminating in-patient medical care for poor and disadvantaged Americans. Something is terribly wrong with a system of health care that spends more and more money to serve fewer and fewer people. And the same scenario could be painted with respect to physician services and fees.

The economics of health care are peculiar. Its economy, though *laissez-faire*, is not *freely* competitive, and hence it has virtually no moderating controls working on behalf of the consumer (the patient). In most other areas of our economy, the marketplace does exercise

some control over arbitrary rises in charges to the consumer. There really *is* competition. Even when that competition is rather thin, it provides some assurance that ineffective, uncompetitive, high-cost, low-quality enterprises will fail. But in health care, prices have gone up regardless of the quality of care being delivered.

Try as it might, the medical profession has not achieved much success in self-regulation. Physicians can help put the brakes on some general expenditures, but very few physicians can honestly and effectively control the delivery of service—much less control the costs of that service—while caring for an individual patient at the bedside.

What is the effect of a health care system distinguished by a virtual absence of both self-regulation on the part of the providers—that is, hospitals and physicians—and the controls of competition regarding price, quality, or service?

One has been the emergence of three tiers of health care, despite the objections of many to even a *two*-tier system. The available options in the face of this reality are two, and both require major changes. Either we maintain the diversity of the American health care system, keep it in the private sector, and demand the rewarding of efficiency and quality with more patients rather than more money; or we go to a government cost-controlled system.

Experience the world over has shown that when government economic controls are applied to health, they prove in time to be detrimental. Eventually there is

When Dr. Koop spoke about the need to respond to the woman contemplating an abortion, he challenged the community — if it seriously opposed abortion as an option — to look at the services that ought to exist for that pregnant woman and the services that ought to be eventually available to that child. That's a down-the-road response to the event of abortion. But we also need to look back up the road and ask what we know about the circumstances that led to that unintended pregnancy in the first place. What have we done to put in place community-wide systems that help sexually active individuals contemplate the potential results of sex before the pregnancy happens?

—Kristine Gebbie, R.N.,
Secretary, Washington Department of Health

The health care system in America today does not respond at all to some 12 to 15 percent of our population. We need to change that system. We need to change it thoroughly, and we need to do it soon.

erosion of quality, productivity, innovation, and creativity. The replacement of physicians by nonmedical bureaucrats as controllers of the system usually results in lack of responsiveness to patients. And finally, rationing and waiting lines become necessary.

Governmental cost controls cannot be the answer, but can we succeed in the alternative course? I'd like to think we can—because we *have* to—and especially because we've met similar challenges before.

Some fifty years ago, for example, we knew that it was morally wrong for our society to allow its old people to drift into poverty and starvation, so we enacted a Social Security law to assure every American a measure of human dignity and respect in his or her twilight years. It was an act of fundamental decency. We knew we had to do it, and we did.

Back in the 1950s and early 1960s, Americans became painfully aware of the terrible unfairness of "separate but equal" education, and the courts and legislatures began the process of ridding our country of the crushing official, legal burden of segregated schools.

Did we get rid of those burdens once and for all? Well, not exactly. We haven't yet solved every problem associated with "growing old in America." We know that. And we haven't yet produced the perfect egalitarian school system. We know that, too. But we have lifted from the shoulders of our people a large part of the burden of shame and guilt that came with doing nothing. We did what was morally right for this country, and we must do that again.

Let's finally say what we've failed to say for too many years: our current system of health care is not fair, not just, and therefore not the morally strong system that our society needs—and deserves.

I will conclude with a few words about the church and the churches. There was a time in the Christian church, at least, when those propagating the gospel were afraid that concern for the welfare of one's fellow human beings might be considered a distraction from the principal concern for the salvation of the lost. In recent years, I believe, thinking people have been able to espouse social action as part of the effect that the gospel is supposed to have on the lives of men and women.

Some of you remember the criticisms of social programs in the early years of the first Reagan term. Although the president himself talked about a safety net, it wasn't quite clear to everyone what he meant, what the dimensions of that net were, how strong it might be, and especially how universal. In those days I had a title and very little to do while I was waiting for confirmation. I got a call one day asking if the churches were part of the safety net. Without even thinking, I said yes. I was raised to consider my church and my family as a safety net (although of course we didn't call it that) for those less fortunate, either in health or in worldly goods.

Yet today many church people separate their faith from action. I recall a time when our children were small and we had a live-in housekeeper—a devout

Christian—who helped with cooking and cleaning. On one night of terrible crisis with children sick, emergency calls for me from the hospital, and so on, a house guest went into labor and delivered, precipitately, a premature baby just down the hall from where our housekeeper was sleeping.

She never appeared on the scene. When things had calmed down, some ten hours later, my wife asked where she had been and why she hadn't come to help. Her reply was honest, straightforward, and simple: "I knew you were having many problems, so I lay in bed and prayed for you all."

If prayer is communication with God, I'm sure she wasn't listening. The divine message must have been clear: "Get up and help!"

Faith in action! It should go without saying that church members should be politically active, understand issues, vote properly, and make their representatives understand what they believe and what they want to see accomplished. We may believe in wholeness, in fairness, and in justice, but if we were exercising all those virtues, there would be no need for a conference on the topic of the church's challenge in health. I will, however, dwell on several obvious gaps in the outreach of the church—and I will speak about the Christian church because that's the only one in which I have had any experience.

Three ethical issues have been very much a part of the social relief system and the political activity of churches: abortion; the care and feeding of handi-

Even if we had a billion points of light in this country on the medical care issue, I don't believe we could supply the currently unmet needs, either for preventive and primary care or for acute care. Volunteerism, though very important, is just not enough. Churches and church leaders are urgently needed in two other roles: as advocates for those with limited access to health care and as participants in discussions about resource allocation.

—Patricia Butler, J.D.,
Health Policy Consultant,
University of Colorado

It's not just the churches that don't get excited about prevention. The medical and nursing communities don't always get excited about prevention. The newspapers don't get excited over prevention stories. Citizens may find it more boring to eat right every day of the week than to dash to the hospital for some exciting new cholesterol test they've just read about.

—Kristine Gebbie, R.N.,
Secretary, Washington Department of Health

Faith in action! It should go without saying that church members should be politically active, understand issues, vote properly, and make their representatives understand what they believe and what they want to see accomplished.

capped children as exemplified by Baby Doe; and the plight of the elderly, which leads all too often to a discussion of euthanasia. Each of these presents a specific challenge to churches.

I am opposed to abortion but have always admonished any church audience I've spoken to that it is not enough to oppose abortion unless the church is willing to extend understanding, shelter, nurture, and economic aid to a woman who is carrying an unwanted pregnancy and seeking a way out.

It is not enough to oppose withholding fluids and nutrition from handicapped newborns unless the church is equally willing to stand by the parents of the handicapped child. Many parents simply lack the resources—whether material, social, psychological, or moral—to care for a disabled child, even in their own family. Having spent my life with Baby Does, I can assure you that a great many loving, caring parents have been engulfed in despair. But I can also assure you that this despair can be alleviated by the timely assistance of a whole range of private community resources found in the churches. The burden of getting a handicapped child to a clinic for a rehabilitation visit can surely be lightened by a church member who offers to care for the other children during the parents' absence.

It is not enough to bemoan the plight of the elderly if the church is not attentive to the needs of people who face the problems of living with an elderly family member. Church members can provide a respite for the family or the individual almost overwhelmed with the

burden of caring for an incapacitated elderly individual.

In my preparations for writing *Whatever Happened to the Human Race* with Francis Schaeffer, I learned a great deal about the attitudes of people in nursing homes. Their greatest fear was abandonment. Indeed, abandonment by family and friends has been shown to influence the type of care and therefore the mortality of individuals in nursing homes. Think how the church could fill this void!

And finally, the issue of AIDS must be faced by American society and particularly American congregations. Until this point, we've been able to deal with AIDS within the familiar public health model of compassion and restoration: the American people feel bad when any of their number get sick, and they truly want to help. They also feel they are sufficiently rewarded by the return of the ill or disabled person to his or her family, community, school, or workplace. That's restoration.

AIDS draws upon the great reservoir of compassion in this country. Except for the final weeks of a terminal AIDS-related illness, a person with AIDS may continue with a normal routine of family life, work, education, and leisure activities without endangering other people. But restoration is far from assured. The mortality rate for AIDS is essentially 100 percent. And after several years of intensive public education on the subject, the American people may not be inclined to be forgiving and compassionate with someone who *today* engages in casual, unprotected anal intercourse or shoots illegal drugs with a used needle and catches AIDS.

I have been preaching and teaching that we must fight the *disease* of AIDS—not the people who have it. And I still believe that has to be our attitude. But I'm also a realist, and I don't see Americans' keeping that distinction clear in their minds much longer.

The cost to the nation's treasury is already beginning to mount well beyond anything we could have imagined two or three years ago. The average annual cost for the care of a single person with AIDS ranges from \$40,000 to over \$100,000, depending on what you include in the computation and whether you are on the West Coast or the East Coast. Multiplying the mean cost by the current annual caseload of 33,000 patients yields a theoretical cost of patient care this year that could exceed \$2 billion.

And this is terminal care for some individuals who, despite public advice to the contrary, choose to do something risky. They have gambled—and lost. So the cost of compassion without restoration is already very high, and it can only get higher until we find a vaccine. Because we are still several years—maybe a decade—away from the development and release of an AIDS vaccine, it is absolutely essential that we view this problem with clear eyes. Then, with the same clear eyes, we must put aside our natural instincts to be vindictive or holier-than-thou or to say “I told you so”; we must instead pursue the traditional, nonjudgmental American course of public health care.

The burden of delivering this message unfortunately will fall most heavily upon the leadership of the black

From 1959 to 1980, we in the human services part of the religious community were called by the government “partner.” Then all of a sudden we became the “safety net.” A word should be spoken about the safety net. We fed four and a half million people in this country last year—was that prevention or treatment? We had 23,000 volunteers in 1981; we had 177,000 last year, but that's just because we got more shelters and bread lines. I'm frustrated that a public official came and said, “When the American spirit rises to the occasion, it can do wonders,” and gave the Social Security Act and civil rights movement as examples. Because when we got to the conclusion, we went back to the safety net: giving a little more bread, setting up another shelter, taking in a pregnant girl—it's just not the answer. We deceive ourselves, we act against our faith if we think that's the answer, especially when our churches have de facto economic and racial segregation. We need to be about the business of affecting policy.

—Thomas Harvey,
a conference participant

community, where the sharpest and most alarming increases in AIDS cases are being reported—direct results of the drug epidemic in that community. I can only hope and pray that American blacks have learned from the early experience of the homosexual community and will not politicize the issue. In public health matters, political posturing costs lives; it does not save them.

The good sense and good heart of the American people—of *all* the American people—must be appealed to and mobilized for the remaining years that this aggressive and vicious disease survives among us. ☸

We really do have something of a three-tiered medical care system in terms of financing. Despite Medicare's problems, the elderly in this country do have the benefit of access to primary and acute care through that program. Their very substantial protection is financed partially by the premiums that the elderly themselves pay for physician services under Medicare, but also by the taxes being paid by those of us in the work force now. For less than half of the very poor in this country, we have the program of Medicaid, financed by state and federal taxes to the tune of over \$50 billion. The two-thirds of the U.S. population who receive health insurance through their workplace actually benefit from over \$40 billion in federal subsidies because of the special tax treatment of health insurance. So the 80 percent of those working poor families who have no health insurance are subsidizing all the rest of us who have health insurance. It actually comes out of their pockets as taxes, yet they don't get any of the benefits either through their workplace or through these public programs. That is a significant inequity.

—Patricia Butler, J.D.,
Health Policy Consultant,
University of Colorado



Health Care in the U.S.

Facts and Choices

James O. Mason



Among the major health issues in the United States today, the weaknesses of the nation's medical care system figure prominently. Our country's health care system is fragmented and costly. In addition, nearly 37 million Americans are uninsured or significantly underinsured. Most of these people are working poor and their dependents. They earn too much to qualify for Medicaid and too little to buy private insurance or to pay directly for medical care. Too many find it economically preferable to join or rejoin the ranks of the Medicaid-eligible unemployed, and few incentives for sustained independence exist.

We need a health care system that guarantees high-quality care, access to all, affordability, and an orientation toward prevention. At the direction of the Secretary for Health, the undersecretary of the U.S. Department of Health and Human Services will be making recommendations to reform our financing of health and long-term care. Successful reform, we realize, will hinge on our attention to the needs of those who are disadvantaged by current policies and programs. The current Medicaid program must be made more equitable and more attractive to potential providers, with continued efforts to improve quality and control costs. In addition,

we will need to explore the creation of partnerships among federal, state, and local governments, the private sector, and churches to strengthen the health care delivery system and make it more responsive to the needs of the poor.

Although the gaps in health care delivery in the U.S. are prominent, this century's successes in public health should not be minimized. Furthermore, the dramatic progress made in lengthening the lives of most Americans and improving the quality of their lives offers lessons for our present course of action.

Life expectancy has increased by over twenty-five years in this century alone—a 50 percent gain. In other words, every week since January 1, 1900, the average American has gained two days of life. (The average non-smoker has in fact gained 3 days per week, while the average smoking American is stuck with the life expectancy of the 1960s.) Most of this increase is due to disease prevention rather than treatment. Improved sanitation has provided safer milk and water supplies, and nutrition for most Americans is better. Immunizations and improvements in maternal and child health have made the most difference. Over the past quarter-century, mass vaccination programs have reduced the incidence of measles, mumps, rubella, tetanus, diphtheria, pertussis, and polio by more than 98 percent.

In 1985 the Carter Center of Emory University and the U.S. Centers for Disease Control (CDC) listed the fourteen primary causes of illness and death in the United States. Some of these are infectious disease,

substance abuse, cardiovascular disease, cancer, dental disease, alcoholism, unintentional injury, and homicide/suicide. Together, these causes are responsible for 85 percent of all health care costs and 80 percent of deaths in the U.S. They also account for 90 percent of the potential years of life lost because people die unnecessarily before they are sixty-five years old.

Two-thirds of the total years of life lost by Americans before the age of sixty-five are preventable. An estimated 45 percent of cardiovascular disease deaths, 20 percent of cancer deaths, and more than half of disabling diabetes complications could be prevented through improved and broadened application of existing preventive measures and risk reduction strategies. Nearly two-thirds of Americans are too fat, and more than a third are at least 10 percent over the recommended weights for their health, body build, and sex, according to a recent nationwide health survey. Many of our modern plagues thus have a strong behavioral component, presenting public health and all American institutions with a serious challenge in communication and motivation.

Infant health is another area of concern. In 1988 in the U.S. almost 39,000 babies died before they reached the age of one year. And annually, an estimated 400,000 babies who have been subjected to a less than optimal intrauterine or perinatal environment develop a chronic disabling condition. America's infant mortality rate ranks twenty-second among industrialized nations—twice as high as Japan's and those of the Scandinavian

If people are uncomfortable talking about moral values in the public square, if society has backed away from moral absolutes, if the schools are compelled to maintain a mythical “value neutrality,” how will children learn to behave in positive ways?

countries. Black infant mortality is double the white rate, and the rate for whites ranks only twelfth world-wide.

If we just applied what we know about prenatal care, case management, outreach, and home visiting, an estimated 10,000 of the 40,000 babies who die each year could be saved and the benefits in human and economic terms would be enormous. In 1988 the National Commission to Prevent Infant Mortality estimated that the hospital costs for low-birth-weight babies were in the range of \$2 billion annually, while the costs of providing early prenatal care to every woman not receiving it were as low as \$500 million.

The clear conclusion of the Carter Center–CDC consultation was that we are not dependent upon additional medical knowledge and research breakthroughs to achieve an enormous improvement in health. We can become a much healthier people by making more effective use of the knowledge of prevention and interventions we already possess.

Part of the challenge is to adapt traditional public health tools like epidemiology and surveillance for new applications in health-related fields. Injuries and violence, for example, are leading causes of death and disability which have not, until recently, been attacked as health problems.

Another part of the job is to be able to respond effectively when a new threat to health appears. AIDS, a disease totally unknown eight years ago, is now the highest cause of death in New York City for males be-

tween the ages of twenty-five and forty-four. We don't yet have ultimate answers to the treatment of AIDS—but we know enough to stop the transmission of the virus from one person to another and to mount educational programs that will help people avoid putting themselves at risk for getting the HIV infection and AIDS.

The Carter Center–CDC study also identified a number of risk factors associated with the fourteen primary health problems, and many of these risks can be removed by individual choice. Most frequently cited were use of tobacco and alcohol, uncontrolled high blood pressure, unintended pregnancy, injury risks, lack of preventive medical services, and improper nutrition. Tobacco was identified as the single leading cause of preventable death. About 1,000 preventable deaths occur in the United States each day—or 360,000 deaths per year. Use of alcohol was the second most important risk factor.

There is good news about progress against the diseases that kill Americans today. First, smoking is down about 25 percent over the past twenty years. This is a major public health gain against such diseases as lung cancer, emphysema, and heart disease. The decrease in lung cancer in males parallels the decrease in smoking, while it is still increasing for women. (Tobacco advertising targeted to women, the poor, and minorities is still winning converts to the ranks of smokers.) Second, from 1950 to 1970, the incidence rates of invasive cervical cancer fell by more than 50 percent, and the rates are

continuing to decline. The National Cancer Institute credits this success to earlier detection (the Pap smear) and treatment. Third, in the past twenty-five years, mortality rates for coronary heart disease declined 40 percent and for stroke by 25 percent—due in large part to control of high blood pressure, cholesterol, and smoking.

This progress is promising, but it cannot trigger complacency. We still find in this country a pronounced and stubborn disparity between the health status of minority Americans and the rest of us. A 1985 report by the Task Force on Black and Minority Health commissioned by the Secretary of Health and Human Services gave evidence that more than 60,000 excess deaths occur each year among America's minority citizens. (*Excess* is defined as deaths that would not have occurred had mortality rates for minorities been as low as those for whites.) These are preventable deaths. The report identified six areas in which an overwhelming difference exists between the health status of white Americans and that of minorities: cancer, cardiovascular disease, diabetes, homicide, injury, and infant mortality. AIDS has subsequently been added to the list because it also disproportionately affects black and Hispanic Americans.

This disparity bears the clearest witness to our failure in achieving the health goals that are realizable, given the current state of scientific knowledge. Bringing equal opportunities in health to all U.S. citizens depends on increasing our efforts to educate people about good health. Prevention is the key to equity in our

If we are trying to deal with the gap between what is known about health promotion and disease prevention and what is applied by the nation's citizens, we need to be talking about people's concepts of self-worth. If a person doesn't believe in the possibilities of the future, then what difference does health information make? A young man in the inner city may be warned about the dangers of casual sexual relationships, but he is likely to reply: "I'm not going to grow up and be in charge of the space around me. I'm not going to decide who gets hired and fired. I'm not going to move resources from this part of the planet to that part. I'm not going to get a job; I'm not going to do anything. The only way I can control my environment is to control people. How am I going to control people? Through violence and through sex. Who ever tells me I'm valuable and worthwhile in this country? Only the woman I make love to. And you tell me to stop?" The health message is absolutely irrelevant in such a social context. That's not work for the health commissioner. That's work for the church.

—Dr. Reed Tuckson,
Commissioner of Health,
District of Columbia

The challenge for all of us who are active in churches and synagogues is to articulate clearly the relationship between right behavior and good health.

health future, for infants, children, and adults. One of my personal goals by the year 2000 is to help assure comprehensive health education classes from kindergarten through twelfth grade in every school in the country.

Because modern plagues are behaviorally driven, the choices we make on a day-to-day basis largely determine whether we will suffer from sexually transmitted diseases including AIDS, become incapacitated by addictive substances, become pregnant teenagers, die prematurely from cancer or heart disease, or suffer traumatic injury or death.

Action and responsibility for control of behaviorally based disease lies ultimately with the individual, but communities, churches, and families have significant roles to play. Let me illustrate with two examples of community-based behavioral change.

In 1978, concerned citizens in a Maine community noticed a high number of auto fatalities and injuries associated with high school graduation activities and resolved to do something. In Project Graduation, the city, the school, churches, and parents became partners to help their teenagers develop alternative alcohol-free graduation activities, along with ways to avoid drinking and driving. This community resolve resulted in the elimination of teen alcohol-related auto fatalities during the graduation period each year thereafter. Communities in over two dozen states have since adopted Project Graduation, and it has clearly reduced a major health risk among adolescents.

A second example is a program sponsored by the Emory University School of Medicine: "Helping Young Teens Postpone Sexual Involvement." One-third of the school districts in Georgia use the curriculum, which is presented by community volunteers. The program has now been presented to 40,000 teenagers between the ages of thirteen and fifteen, and the results are declines in pregnancies, abortions, and birth rates over the last three years. A program evaluation shows that 5 percent of the participating teens became sexually active, while 15 percent of a matched comparison group became sexually active.

The point should be obvious to church and synagogue leaders: behavior is value-laden. If people are uncomfortable talking about moral values in the public square, if society has backed away from moral absolutes, if the schools are compelled to maintain a mythical "value neutrality," how will children and adolescents learn to behave in positive ways that do not put them at risk for life-threatening diseases? If our churches and families do not nurture positive moral character—including integrity, responsible self-reliance, self-discipline, self-esteem, and charity toward others—our children will increasingly give in to high-risk behaviors.

The participation of churches and synagogues is needed in this endeavor, and their involvement is historically grounded. Although traditionally the church has been concerned with the whole person—both spirit and body—modern secular society has focused more sharply on the body because people disagree about

matters of the spirit. No matter which aspect of the spirit we emphasize or how we relate body and spirit, however, we surely agree that the medical maladies we seek to relieve have a substantial spiritual component.

Familiar scriptural passages attest to the long history of the holistic approach. Moses gave directions to ancient Israel on both treating and preventing disease. By avoiding pork, trichinosis was prevented. Treatment and prevention strategies for leprosy, boils, and ulcers were provided. Sanitation was clearly part of their religious life. For example, Moses taught:

And you shall have a place outside the camp, where you may go out; and you shall have an implement among your equipment, and when you sit down outside, you shall dig with it and turn and cover your refuse. (Deuteronomy 23:12, 13)

The Scriptures also contain clear instructions regarding the expression of human sexuality. Abstinence from sexual activity until one enters a stable marriage relationship is prescribed for spiritual and social reasons. The sexual prohibitions promoted health and welfare by preventing sexually transmitted diseases, out-of-wedlock pregnancy, and the trivialization of sexual expression.

In the New Testament Paul taught that the body is the temple of God. "Know ye not that ye are the temple of God . . . if any man [or woman] defile the temple of God, him shall God destroy; for the temple of God is

Congregations can do a great deal in the area of health education and preventive health measures by sponsoring such activities as health fairs, parenting projects, blood pressure and hypertension clinics, and other health screening programs. Monitoring important health legislation at all levels of government and advocating legislative action that deals justly with health problems can have an influence. Churches can also organize community action groups to alleviate such health hazards as unsafe working conditions in local industry and unhealthy living conditions in local housing.

—Sister Mary Madonna Ashton,
Health Officer, State of Minnesota

We at the federal, state, and local levels of government can pass laws and ordinances to restrict unhealthy behaviors and establish some sense of awareness about the death and disabilities that unhealthy life-styles cause. But we unfortunately do not instill the confidence or trust that religious leaders bring to their congregations about such matters. They can reach people who are not open to or cannot be reached by government messages.

—Sister Mary Madonna Ashton

Many of our modern plagues have a strong behavioral component, presenting public health and all American institutions with a serious challenge in communication and motivation.

holy, which temple are ye.” The body’s role as a temple or tabernacle for the spirit provides an added incentive to promote health and prevent disease. The scriptural commands to demonstrate concern for the sick, lame, halt, blind, and deaf reinforce the concept of the body as temple, as do the commands to love others as we love ourselves.

But one need not turn to past religious experience for examples of promoting health, compassion, and caring; such behavior continues to characterize the work of most contemporary churches. Churches including Seventh-day Adventists and the Church of Jesus Christ of Latter-Day Saints have proscribed tobacco, alcohol, and other addicting substances, encouraged diets rich in fruits, vegetables, and whole grains, and prohibited use of meats or recommended sparing use. And studies of members of religious organizations indicate that churches with teachings on health are capable of influencing life-style and behavior, thereby leading to disease reduction. For example, studies have shown that members of the Mormon church living in Alameda County, California, experienced an adjusted cancer mortality rate only 55 percent as great as that of the whole country. Reduced rates of cardiovascular disease and cancer mortality among Seventh-day Adventists have been documented. Churches and synagogues are obviously equipped to make a significant difference in the health of the nation if they will articulate the health benefits from their various traditions.

Our nation’s families must also participate. They

must nurture moral character in children, which comes only through training. The church should then encourage and fortify the home, and society as a whole should not make the job of the family any harder than it already is. As President Bush has observed, we need to find “ways to preserve and strengthen indispensable institutions like the family in the midst of social change. As I look at the fabric of society and at the instability of family relationships, I see a real threat to our future.”

I would like to conclude on a personal note. I am proud to be the father of seven children. My wife and I endeavored to love and accept them rather than berate them. We gave them time rather than things. We tried to teach them the value of work, honesty, and individual responsibility. We taught them why they should avoid drugs, alcohol, and premarital sex. In other words, we endeavored to cultivate moral character, and we’re satisfied that our efforts were not wasted—they are a great bunch of human beings. During this process our church provided my wife and me with a value system, technical assistance, wholesome family-centered activities and worship, and always encouragement. We would not have succeeded without help from our church.

The challenge for all of us who are active in churches and synagogues is to articulate clearly the relationship between right behavior and good health. Many keys to good health in the Judeo-Christian Scriptures are as valid today as they were two or three thousand years ago. We need to help people, especially young people, understand that many diseases and illnesses

are direct or indirect results of behavior that we've been told to avoid. But beyond talking about it, we have to be good role models ourselves. ☸

In 1989 the U.S. will probably spend \$600 billion, almost 12 percent of the GNP, on treatment, but we're putting a fraction of that into prevention. As a nation, we're underfunding what we can do to prevent disease. As an example, for lack of \$500 million for prenatal care, we spend \$2 billion for treatment. Four times more for treatment than prevention, and we don't in our treatment cure! We end up often with infants who are going to be severely impaired for the rest of their lives. So after spending the \$2 billion, we still don't have what we would have achieved had we spent the \$500 million on prevention.

—Dr. James O. Mason,
Assistant Secretary for Health

In the District of Columbia, a city of 610,000, we have 117,000 people with no health insurance. That statistic is typical of the urban American experience and an extremely difficult problem for a local jurisdiction to solve by itself. Without some national legislation, a national commitment to health as a priority, we will never make it in the District of Columbia; we will wind up with a piecemeal approach, and people will still die because of not having access to health care.

—Dr. Reed Tuckson,
Commissioner of Health,
District of Columbia

We of the Abrahamic faiths—Judaism, Christianity, and Islam— should not follow public opinion. It should be the other way around: we should create and lead public opinion according to our standards of ethics and morality.

—Hisham Altalib, Director,
International Institute of Islamic Thought



Accepting Our Responsibility

Jimmy Carter



To talk about the church's challenge in health is to talk about a new responsibility, and for most of us accepting new responsibilities is very difficult. Even when we're faced with a crisis that we commonly recognize, we often seek to put it off on someone else, on some other organization that is either nonexistent or also unwilling to assume new and vital duties.

We face gaps in our lives—gaps between our personal dreams and our genuine, proven accomplishments, and gaps between a rapidly evolving science and technology, on the one hand, and the moral and ethical understanding that are necessary to accommodate rapid change. We face as well an apparent incompatibility at times between science and deep religious faith. (I should add here that I don't personally experience anguish or pain on this score because the more I know about the complexities of the universe—its broadest dimensions in space, and its subatomic detail—the more convinced I am that my religious faith is sound.) We face a gap also between our ideals in life, our religious ideals, the ones that we profess as paramount, and what we actually do in practice. This gap can extend through a day of existence, a week, a month, a year, and an entire lifetime. It's so easy to rationalize a delay, we say, "Well,

when I am financially secure, or when I reach retirement age, or when I accomplish this next material goal, or when I'm properly recognized by my peers—then I am going to put into practice what my faith requires." These gaps have existed, have been prominent in my own life, and I don't know of an easy solution.

One program that serves as an example of bridging the gap between ideals and practice is Habitat for Humanity, in which Rosalynn and I are involved. I belong to a very nice church in Plains, a small church. Rosalynn and I teach Sunday school every Sunday that we're there. There is very little reaching out from this cozy, compatible, relatively homogeneous group of Southern Baptist Christians to those who genuinely need the ministrations of compassion, understanding, and love. Habitat for Humanity gives me an opportunity to cross that chasm. Through Habitat, which is supported by individual congregations, we work side by side with some of the most destitute people in the world to build homes for them. All of us are volunteers, and many of the materials are donated. Rosalynn and I act as carpenters for just one week a year, and we get a lot of publicity for the program. Rosalynn has learned to pour concrete, erect stud walls, put up sheetrock, lay flooring, or put on a baseboard. But the essence of the program is that we are joined in an equal partnership, not from a position of superiority, with families who perhaps have never before accomplished anything that would bring them sustained pride or even self-respect. We don't take any government money, and we don't

give away anything. The families have to pay for their house, full price, no profit, no interest. The Bible says when you lend money to a poor person you don't charge interest, so we don't. Just moving into the house built through this shared labor can transform the life of that family. Now some principles of the Habitat for Humanity program may very well be applicable to the problem of the church's challenge in health.

How can we break down these enormous, sometimes impenetrable barriers that separate us cozy religious leaders from the people who are destitute, forlorn, neglected, inarticulate, without influence, and actually suffering within the heart of communities in the richest nation on earth? We can easily answer that it's not our responsibility, that one person can do very little, or that the government should take care of it. But I hope we'll instead come to grips not only with the problem but with the opportunities we have. We can look around where we work or live and say, "I myself am going to do something about the health problems in this country if no one else does anything. I'm going to use my innate intelligence, my ability, my innovation, my inspiration, my prayers, my experience, my influence, to bring about an improvement in the health of those for whom I care, and perhaps those for whom I pray, but quite often for those with whom I'm not acquainted." There is a way to break down those barriers and reach out, not as superior beings giving blessings or benevolence but as equals.

I recently learned that one-third of the biblical text

How can we possibly separate circumstances so prevalent in our poverty-stricken neighborhoods from the true and unavoidable responsibility of the church? If this is not our responsibility as religious leaders, what is?

of the four Gospels is devoted to healing by Jesus. He treated the mental and physical afflictions of those who walked the same roads, lived in the same communities, and suffered the same political oppression but most often were outcast, despised, and ignored, condemned, scorned, and punished by Jesus' own associates. The contemporary problem of AIDS, and the way religious believers have dealt with it, comes immediately to mind. I have a problem with AIDS because of its connections with homosexuality, with sex outside marriage, with the use of filthy needles to inject illicit drugs into the body. These links cause me great discomfort. But the reality of leprosy two thousand years ago was not so different. Lepers were perhaps even more outcast, more despised, more condemned, and more avoided than an AIDS victim of today even in his or her worst circumstances. The society held a general conviction—almost unanimous, I believe—that these people suffered from the most horrible disease known because of some sin known by God, perhaps unknown to the one who avoided the leper. And Jesus embraced them, had no hesitancy about touching them or being with them; he ministered to them. He didn't approve either sin or leprosy, but he showed his love for lepers. No matter now conservative a position one takes on the issue of homosexuality, then, it should not be an obstacle to dealing in a kind, gentle, loving, and compassionate spirit with those who have AIDS. The task is still difficult, of course; I'm not underestimating the difficulty.

In setting up the programs of the Carter Center, we have to wrestle with some of these same problems. One basic guideline is that we not duplicate what others can do as well. Second, we seek to be nonpolitical and non-partisan. We try to bring to our conferences both those who are experts on a particular subject and those who can actually implement the ideas or recommendations that are forthcoming. To bring people here who can actually observe what the problem is, learn about it, and go out and do something—that's one of the elements of our center's work.

One of the earliest health conferences we had at the Carter Center was called "Closing the Gap." In it we sought to analyze definitively the difference between what we know how to do in health care—using available technology, not future discoveries—and what we actually do. The results startled even the experts. We had over a hundred experts here: medical practitioners, public health specialists, research scientists, some Nobel laureates. Using the accumulated information of many people doing work in many fields, we discovered that two-thirds of all premature deaths are preventable just by changes in our personal habits. We discovered that 55 percent of all pregnancies in this country are unplanned and many of these unwanted. We tried to learn how devastating a blow such a pregnancy can be not only to the woman but also to the family, and how it precipitates in many cases violence within the home—child abuse, spouse abuse, suicide, homicide. We learned that the primary killer of American people is cigarettes,

the most addictive drug of all, last year responsible for the deaths of 390,000 Americans. Yet little is done; we are silent about this devastating affliction on our society. We watch young people acquire a habit that they cannot break, a habit much more addictive than heroin. They surmise from the silence of church leaders, educational leaders, and parents that smoking is okay. It's sobering for me to know that more Colombians died last year from smoking American cigarettes than did Americans from using Colombian cocaine.

One study was particularly intriguing. An analysis was made of the sufferings (early deaths, addiction to drugs, early unwanted pregnancy, failure to recover from moderate illness, and so on) experienced in a certain poor neighborhood. Some of the suffering could be attributed to environmental circumstances, inherited traits, hazards of the workplace, unavailability of health care, or poor nutrition, but about 35 percent couldn't be accounted for. The researchers concluded that the people's lack of hope was the variable that accounted for the "extra" suffering. The people in the community had no faith that they themselves could change their own destiny, that their decisions would make a difference in their lives. They had perhaps never seen their parents use strength and resolve to overcome a major difficulty. If they got ill or were tempted to have illicit sex or take drugs, or even to commit crimes, they passively went along, thinking nothing they could do would make a difference. How can we possibly separate these circumstances, so prevalent in our poverty-stricken neighbor-

hoods, from the true and unavoidable responsibility of the church? If this is not our responsibility as religious leaders, what is?

Following the "Closing the Gap" conference we tried to construct a health risk appraisal so that people could do a self-analysis. This health risk appraisal is being distributed at more than 1,500 local centers around our country. About 25 questions are asked concerning one's life history and personal habits, including items on smoking, drinking, fastening seat belts, attitude toward firearms; weight and diet; response to stress, strain, disappointment, or tragedy; cause of death of one's parents and grandparents; and so on. These risk factors are analyzed by computer to determine their effect on one's life expectancy. For example, a fifty-year-old man who smokes two packs of cigarettes a day and is thirty-five pounds overweight may have the life expectancy of a sixty-eight-year old. An assessment is also made of the consequences of a change in habits: if the same person stops smoking and reduces his weight by thirty-five pounds, he could add x number of years to his life. This appraisal, which costs just two or three dollars, would be wonderful for church members, for those entering hospitals, for students entering college. It allows people to look at themselves and say, "This is what I am, this is what I'm doing to myself, and this is what I change to give me a longer, healthy, and more productive life."

But the circle of responsibility is wider than concern for our own health as individuals. In closing I'd like to

It's sobering for me to know that more Colombians died last year from smoking American cigarettes than did Americans from using Colombian cocaine.

outline briefly some of the international initiatives of the Carter Center, because they remind us of the larger horizons of concern for human health that the church needs to keep in view.

First is a task force on child survival, under the direction of Dr. William Foege. Dr. Foege and his group have contracts with the World Health Organization, UNICEF, Rotary International, and the Rockefeller Foundation, among others, to coordinate on a global scale the immunization of children against polio, measles, diphtheria, typhoid, and whooping cough. They are also working to implement the increased use of oral rehydration therapy, which prevents the diarrheal diseases fatal to so many of the world's children.

Second is a recently formed task force on disease eradication. In 1988 polio and guinea worm were targeted. For the last four months there have been no reports of any wild strains of polio in this hemisphere; it will take ten more years to eradicate polio in Africa and Asia. Guinea worm afflicts about 10 million people a year in twenty-two countries, mostly in the sub-Saharan region of Africa. The Carter Center is taking the leadership role in eradicating guinea worm: we now know how to do it, and through education and proper application of principles we hope to succeed by the year 1995.

A third initiative is in the area of nutrition. We are aware that health, nutrition, and food availability are intimately related, but we face the reality that the per capita production of food grain in Africa has decreased

every year for the last twenty years. Dr. Foege estimates that the caloric intake of the average African has declined at the rate of about three and a half calories per year—about seventy calories over twenty years. And these people already had a substandard diet. The Carter Center has responded by organizing a program called Global 2000, charged with beginning a green revolution in sub-Saharan Africa. We have joined with others under the direction of Nobel laureate Dr. Norman Borlaug, who orchestrated the green revolution in Pakistan. A couple of scientists seek native farmers to volunteer to plant experimental plots; they plant about one acre in their traditional way and about one acre using the right seed and fertilizer (two acres is usually about all the land they have). They plant with a pointed stick and cultivate with a hoe—no machinery is used—but they have been able to triple production. In Ghana (a country with leadership that wouldn't be welcome in the White House), 40 farmers participated in 1986; 1,200 farmers in 1987; 16,000 in 1988; and 85,000 in 1989. The eagerness, excitement, hard work, and dedication of these African farmers and their leaders when they see an opportunity to help themselves are extraordinary. With 85,000 farmers, we have only three employees in Ghana. All the rest are Ghanians, and they are learning in the process how to help themselves.

The last initiatives I'll mention are those for peace. We realize that our programs in the Third World cannot be successful in the midst of a war. When I was in the White House, I became painfully aware that most of the

wars on earth, about 95 percent of them, are civil wars, wars between an existing government and revolutionary forces. (The Iran-Iraq war is a rare exception.) But the charters of groups like the United Nations, the Organization of American States, the Organization of African Unity, and the Commonwealth countries specifically prohibit their officials from dealing with revolutionaries who are fighting against a member government. And many countries (the U.S., Great Britain, France, the Soviet Union, for example) have standard policies that specifically prohibit their ambassadors from dealing with revolutionaries fighting against the officially recognized government. For about 95 percent of all wars on earth, then, there is a strict prohibition against the involvement of major nations or international agencies in resolving the conflict through peace negotiations. We have taken on that task. Through an international negotiating network, we're now reaching out to revolutionaries and talking to government leaders who want to have some communication. For example, the Ethiopian government team was here in September 1989 along with a negotiating team from the Eritrean People's Liberation Front. This war has been going on for twenty-eight years; a million people have died either directly or indirectly from the deliberate withholding of food.

In concluding I want to affirm the Carter Center's interest in following up this conference. One way would be for us to provide a constant flow of information about health issues to be used in church bulletins and denominational periodicals. We could be a clearinghouse to let people know of successful health models that might be developed in their own churches and denominations. And we'd like for this to be a continuing process.

All of us are in an exploratory phase. We need to work together to understand what the issues are, but we also need to minimize the ingrained prejudices that limit the scope of our minds and hearts. It would be helpful if we could set goals that are truly exciting and challenging and adventurous, and perhaps unpredictable, that would catch the imagination of people in our churches and denominations. I don't know what's going to happen, but I want to be a part of it. I hope that we can break down the barriers that exist between ourselves and others about whom we study and for whom we pray but whom we probably don't even know. That effort will require tremendous faith—in ourselves and our capabilities, in those we'd like to serve, and in the God we worship. ☸



The Vision of the Possible

What Churches Can Do

William Foege



David Hilton, a physician and the associate director of the Christian Medical Commission, World Council of Churches, has observed that health is primarily dependent not on medicine but on education. I believe that churches have special opportunities to educate their parishioners about health. Most important, they can provide a larger and more complete vision of health. Churches can make a difference in at least five areas of education.

First, the church can teach us about the unity of body and soul and about the damage caused by our inability to see people as wholes. There is a unity to the idea of brokenness, whether we are talking about sin or disease or depletion of the ozone layer or homelessness. There is also a unity to the idea of redemption, whether we are talking about forgiveness or healing or environmental improvement. I have learned that there is redemption in a syringe of penicillin, in a syringe of measles vaccine: they make whole what is broken or keep whole what is not broken. I have learned that salvation means wholeness and not just life after death. For some people these are new ideas, and we know that the mind approaches new ideas the way the body approaches foreign proteins—it tends to reject them. Nonetheless,

churches need to be teaching these ideas.

Second, the church needs to do a better job of teaching the unity of people: that we have a responsibility for others and that the idea of loving our neighbor is not just a religious idea but ultimately the measure of civilization. The measure of civilization is not found in knowledge or technology or even happiness. A civilized society is defined by how it treats other people, and a civilized person, a civilized institution, or a civilized church is defined in the same way. It is easy to respond to our neighbor during an earthquake or a famine, but it is harder to respond to the miseries and chronic problems of everyday life. The unexpected may open our hearts momentarily, but for most of us most of the time, avarice is the sphincter of the heart and the challenge to the church.

Third, the church could do more education on the overlapping of medicine and religion, of science and religion. Lily Tomlin once remarked that when we talk to God the church says we are praying, but when God talks to us the doctor says we are schizophrenic. The boundaries are artificial; they are defined too narrowly by both sides. Medicine describes, defines, and measures illness. It provides a diagnosis, and it attempts an intervention. Yet the church provides a sense of continuity, a flow of history, a way of explaining health and illness. Theologian Thomas Droege has pointed out that both scientists and theologians have an incomplete view of the world. His new book on the faith factor in healing makes the point that a disease cannot be

described outside the story of a person's life, beliefs, family history, and faith tradition. Einstein said that though it might be possible to describe everything scientifically, the description would make absolutely no sense. This admission should not be an opening for medicine-bashing, however. Each of us owes a great deal to medicine, and many of the seats at this conference would be empty if we didn't have the gift of medicine.

But the church goes beyond that. It brings order, meaning, and purpose into the lives of people, into the lives of communities. It facilitates healing and the maintenance of wholeness.

The placebo presents an interesting illustration. I learned in medical school that a study of an unknown drug should compare the drug with a placebo that has no action in order to determine what the drug will do. What I did not learn in medical school is that the placebo is in fact faith. So we are not testing a drug against nothing; we are testing a drug plus faith against faith alone. We have no controls testing against nothing. The medical literature is filled with thousands, even millions, of experiments on placebo effects, but these are actually measures of something against faith. The church can enlist that faith; doctors do. They give an expectant attitude to patients; they encourage the placebo effect. Donald Shriver has said that the medical profession would be ill served by members who did not appreciate the real powers of medicine, and so also with the field of religion.

There is redemption in a syringe of penicillin, in a syringe of measles vaccine: they make whole what is broken or keep whole what is not broken. I have learned that salvation means wholeness and not just life after death.

The church brings its own resources to bear on healing, and some of these resources are words. Words can be used to enlist people in their own destinies rather than allowing them to be passive observers. The philosopher Primo Levy, a Holocaust survivor, attempts in his book *The Saved and the Drowned* to understand what he had learned at Auschwitz. He makes the point that believers in any faith better resisted the seduction of power and had the best defense against death. Thomas Droege has observed that a person with close ties to a faith tradition that has met the test of time is likely to have a strong sense of coherence. Coherence is related to wellness, and fatalism, lacking coherence, lacks wellness. Churches must give parishioners the power to fight fatalism, to be involved in their own destiny, and to be involved in the destiny of the world.

Fourth, the church should be teaching parishioners about prevention. Too often we place prevention and treatment in opposition, when they are actually on a continuum. Hippocrates believed that the obligation of protecting and developing health ranked even above that of restoring health when it is impaired, and this is true. Nevertheless, we don't live that way, and we don't spend our money that way. The continuum of illness starts early and only later breaks the surface of consciousness. The football coach Hugh McCabe died at age forty-seven of lung cancer. Before he died he said, "It's hard to get across the idea to teenagers that it's not the last pack of cigarettes that kills you; it's the first." Things are broken with that first cigarette.

So the question is one of perspective. Everything can be seen as healing from that perspective. Everything we do is healing, but the brokenness isn't evident to everyone. On the other hand, all efforts are part of prevention—as we attempt to prevent illness, to prevent the progression of illness, to prevent disability or suffering or pain or death. So there is a continuum that can be appropriately viewed as different levels of prevention or different levels of healing even when we are speaking of the same thing. And as we all realize, some things can't be fixed. Even here, though, the church can give meaning to the partial.

Fifth, the church should teach perspective. Health is not an end in itself. It is not the purpose of life, but it helps serve life's purpose. And we often realize that only when we lose it. Furthermore, the sentence of illness that we allow for others helps to detract from their purpose of life. This week, thirty years after the polio vaccine has been widely distributed in this country and is available on the world market for two cents a dose, 5,000 children around the world are paralyzed with polio. It detracts from their purpose of life.

Be ye doers of the Word and not hearers only. What can congregations do? Every church can review its community's needs in the areas of health, education, primary prevention, secondary prevention, care, counseling, and support and then decide where to begin. For example, the health risk appraisal mentioned by President Carter can be used in a congregation to help individuals learn what they can do for their own health

and also to help decide what priority should be given to providing certain services to the congregation.

We'll need to learn, of course, how to give people information without blaming them for their problems. On the other hand, we can't withhold information because we interpret this as blaming the victim. One of the greatest of earthly blessings is independence, but we don't have it if we are denied the information we need to be independent. We must present information as a way of improving free will. Life expectancy at birth has increased by twenty-five years during this century. That doesn't mean that at my age I can expect twenty-five years more than my grandfather had at this age; by this time we have passed the high infant and childhood mortality levels. At my age, I can expect only six more years than my grandfather had left at the same age. In one sense, then, all of twentieth-century science and medicine can give me only six additional years of life at this age. Yet, a researcher (Lester Breslow) in Alameda County, California, has shown that a person my age doing some simple things—like not smoking, drinking only in moderation, eating right, and exercising—can live eleven years longer than a person my age not doing those things. So in another sense, I am twice as powerful as all of twentieth-century science and medicine in determining my own health destiny.

That is real power, and the church has a role in showing individuals that power. This role leads immediately into smokers' clinics, Alcoholics Anonymous groups, weight-watching groups, counseling, aerobics,

The service roles in society have become unattractive to young people. The numbers of applicants to medical school, dental school, nursing school, and allied health training have declined. When students entering college are asked about their goal in life, fewer are answering "to develop a meaningful philosophy of life"; more are responding, "to develop a comfortable life-style." What does that mean in the long run? Should churches individually and collectively be discussing this declining interest in service roles?

—Dr. M. Roy Schwarz,
Assistant Executive Vice President,
American Medical Association

Only 15 percent of school districts in the country have a comprehensive health education program. That's outrageous! Couldn't the church go into every community and say, "Do you have it? If you don't, why not? We'll lead the charge; we'll pull the group together and make it happen."

—Dr. M. Roy Schwarz

We as the church must have a vision of being responsible for the entire creative order and at the same time understand what needs to be done today at this hour in this small corner of the creative order, believing that God is truly in the details.

flu vaccinations, and so on. It leads to church suppers that emphasize health foods. It leads into health maintenance and injury prevention for older people. It leads to Sunday school materials that teach about healthy living and to collective action for food kitchens and world hunger. Congregations need to know what the state of the world is and receive basic training for how they fit into that world. One guide is the "State of the World," published each year by the Worldwatch Institute in Washington, D.C. It helps individuals see what they could be doing for the world environment. UNICEF's annual "State of the World's Children" is another helpful guide. *Contact* magazine from the World Council of Churches and *Seeds* magazine on world hunger are also useful.

Much can be done at the community level. So far the church has responded only randomly to AIDS—certain congregations, certain people. The school health curriculum is another area. We know that school health curricula can reduce smoking rates by the seventh grade and reduce teenage pregnancy rates. That is no longer a mystery, and churches have a role to play in getting school districts to implement good school health curricula. Churches could become more actively involved in solving problems of drunken driving, child abuse, and spouse abuse.

I recently heard about a woman who organized women in the slums of Dacca in Bangladesh; through her efforts, their children have immunization levels over 90 percent. If this can be accomplished in the slums of

Dacca, why do congregations have so much trouble doing it in the middle of America?

At the national level we must deal with the problem of 37 million uninsured people in a land of medical plenty. To come up with a reasonable and equitable national health plan will take the best thought and action of churches. A church can become the conscience of a community to worry about illiteracy and teenage pregnancy, and a good school health curriculum is needed at the national level, not just at the local level. The power of interdenominational efforts to promote a health agenda would be tremendous. One example should spur us to action. Bob Sanders, a Tennessee pediatrician, treated a child who had been injured in an automobile accident, unrestrained. Sanders decided to try to get child-restraint laws in his county. This led to incorporating a pediatric society in Tennessee, and Tennessee eventually passed the first child-restraint law. Six years later all fifty states had child-restraint laws, without any federal action. One person's effort affected the security of an entire nation of children, and an interdenominational coalition of the church could improve the system in similar ways.

A few words on the global situation. All the domestic inequities we know about have to be multiplied by 10, 100, 1,000 if we are to comprehend the inequities in the developing world. Today, tens of thousands of children are being born into the sixteenth century. They will live short lives with no benefit from all the medical schools in the world, from the discovery of penicillin,

from the proliferation of computer technology, or even from an alphabet. They will not benefit from either an American Medical Association or organized churches.

The basis of public health is to make our science available to all. Yet all the U.S. support for health around the world doesn't make up for the disease burden the U.S. imposes through our economic decisions or our tobacco exports. The U.S. is a net exporter of disease. We need to support the United Nations agencies (WHO and UNICEF), and we need to influence our government. Our government, on the one hand, asks WHO to develop a global plan for AIDS, and on the other hand, doesn't pay its dues. Before President Reagan went to speak at the U.N., our government publicized the payment of its 1987 dues to WHO to avert criticism. It did not pay the arrears.

We can't do everything, of course, but we have to start somewhere. We have to diminish our acts of omission. We have to know what is possible and then select a place to start.

What could our communities of believers become? Henry Ford said there are two kinds of people: those who believe they can and those who believe they can't—and both are right. The churches have to become communities of people who believe they can. They must plan for a long future and sometimes for a very late harvest. But we the church could become the dominant agent working for the health of our parishes, health equity within the United States, and health equity for developing countries.

The catastrophic health care bill is going down to defeat. It would have provided for extended care, drugs, and other coverage by asking people who had taxable incomes to contribute on a sliding scale. The maximum contribution would have been \$1,600 for people whose after-tax income was \$60,000. Sixteen hundred dollars out of \$60,000. And what happened? The people who had the resources didn't want to do it, and they reversed the whole process. How are we going to handle selfishness of that nature? The stage is indeed set for intergenerational conflict.

—Dr. M. Roy Schwarz,
Assistant Executive Vice President,
American Medical Association

Our current national debt is about \$2.6 trillion; during a single day in 1989 we spent \$200 billion on debt interest alone. It would take only \$25–27 billion to provide all health care services to those 37 million people who are underinsured or uninsured. If we didn't have the interest payment we could do that.

—Dr. M. Roy Schwarz

As we all realize, some things can't be fixed. Even here, though, the church can give meaning to the partial.

In the past churches have identified promising young people, put them through medical school, and sent them out to do important work as medical missionaries. What if we could break out of that mold and identify other important concerns in the world that we have to do something about? We could identify promising young people, educate them in political science, engineering, medicine, and teaching, and allow them to be missionaries for the church where they could do the most good.

I find the history of the Jesuits inspiring. Ignatius of Loyola was a contemporary of Luther, and he was caught up in the proud tradition of the individualist dedicated to a larger cause and supported by a community of believers. Those early Jesuits fused action with contemplation; they accepted the world with obedience and with discipline. In India they became Brahmans; in China they became Mandarins; and 130

years ago in the Pacific Northwest they became Indians. They took the problems of each culture unto themselves. They believed that body and soul were not distinct entities but interlocking principles of an entity and that the improvement of the economic or social order was relevant to and necessary for optimal spiritual progress.

We have been given dominance of the world, and health is a gift intended for everyone. This dominion is not a dictatorship; as Droege says, we are in the priestly role of caretaker beginning with care of ourselves and ending with the care of others and the whole creative order. We as the church must have a vision of being responsible for the entire creative order and at the same time understand what needs to be done today at this hour in this small corner of the creative order, believing that God is truly in the details. ☸



A Voice for the Voiceless

The Church and the Mentally Ill

Rosalynn Carter



One of the major causes of unnecessary suffering and death is mental illness. I have worked with mental health programs and those who have mental illnesses for almost twenty years. I've seen the suffering and devastation that can come to an individual and a family when mental illness occurs. With treatment, however, most people can be spared the suffering. Some can overcome the illness completely; others, with medication, can lead more normal lives; nearly all can be helped. This is not known by the population at large, mainly because of the stigma associated with mental illness.

Mental illnesses of all kinds present a tremendous challenge to religious organizations today. In a recent national survey in which twenty religious bodies responded, only two denominations had ministries directed to the needs of mentally ill people. How can religious organizations better minister to the mental health needs of the congregations and the communities they serve?

First, they will need to face the issue of homelessness. Homelessness is everywhere. We see people living on the streets. We accept it; we walk around them. But these people—often ragged, dirty, wrapped in old

blankets, huddling together to keep warm—are real people; they have feelings but little hope. And 20 percent of the homeless are mentally ill. They have stories of being in and out of mental institutions, with no one to care for them. That reality is part of our everyday life now, along with the addictive disorders which we hear about daily and which are affecting people all over our country.

Ministering to the families of the mentally ill is also critically important. How can we the church shed the fear and ignorance that have plagued us for centuries and adequately reach out to families of mentally ill people? A father of a son who suffered from schizophrenia put it this way: “Caught between the needs of the mentally ill person and the bewildering, elusive services available through public agencies, the family eventually acts as its own doctor, nurse, and social worker.” Summing up the situation, he added, “*brokenness* is the word.”

Yes, our churches have a problem reaching out to people who are broken by mental illnesses. Yet if we look carefully, we realize that churches and religious communities themselves may be the victims of this brokenness. Many professional caregivers, including ministers and church workers, discover that after many years of giving all they have they have nothing left to give. They're burned out. As a result, congregations are left in the uncomfortable position of depending on a healer whose spirit is so wounded that it seems beyond repair. Those in a position to make a decision about

I think of advocacy at three levels. First is one-on-one advocacy for a mentally ill person. Those who have mental illness don't often function very well, and they often need a friend. They need someone to get them into treatment, keep them in treatment, help them find a house, help them stay fit. Then there's congregation-wide advocacy: you just organize the above. As a congregation you organize halfway houses and group homes; you fight the fights at the local level to get the zoning. Third is political advocacy—taking on the powers that be. We need to argue with people who refer to those in mental institutions as inmates. We need to argue with people who use loose terminology when they describe the mentally ill, because the mentally ill and their families are also sensitive. We should appear before legislative and congregational bodies and local zoning bodies. And we need to tackle the financial inequities that go with insurance plans for the mentally ill. Finally, research is a very pressing need. We are learning more about treatment, but we don't have a lot of cures. In this time of budget deficits, churches need to stand up for funding of the mental health fight.

—Dr. Thomas Bryant, President,
Nonprofit Management Associates

If a congregation visibly reaches out to one of its own who is suffering from a mental problem, then it becomes possible for a member of that church to say, “I have a mental problem, too.”

these caregivers sometimes respond by pretending that a crisis doesn't exist. Other times they believe that the caregiver's move to another locale will resolve all the problems. Too often churches have sought to ignore a simple reality: that mental illness can come even to those who are providing care.

Perhaps one of the most pressing challenges for the church today regarding mental health is to keep its leaders emotionally and spiritually healthy. The mental health of church leaders is more than just a personal issue; it is a means by which the church can begin to overcome the stigma that surrounds mental illness. If it becomes visible that a congregation recognizes and reaches out to one of its own who is suffering from a mental problem, then it becomes possible for a member of that church to say, “I have a mental problem, too.” When these illnesses are talked about openly, and when people learn that mental illness, like physical illness, can be helped or overcome with treatment—that is when the stigma will begin to disappear, so that we can really minister to those who need our help.

Another issue for the church is that of preventive mental health. We assume that being a member of a religious community is restorative for mental health and preventive of mental illnesses. Yet mental illness does afflict members of congregations, and pastors and church leaders often have little training for ministering to the mentally ill. Many churches in this community are doing wonderful work for the homeless—providing shelters, soup kitchens, and so forth. But when those

who come into the shelter are both homeless and mentally ill, they're different. The church leaders don't know what to do with them.

We need to look to the examples in this country of leaders and congregations who have become sensitized to the needs, overcome the prejudices, and have good ministries for the mentally ill. One is the Panthersville Presbyterian Church, in the Atlanta area. This small congregation was approached by an adjacent mental health facility about using church space for an outpatient activity. Since the church was facing the challenge of just surviving, they decided to rent space to the center. Through this cooperation the church was able to overcome its fears and prejudices and now has a fuller ministry to all people. This happens so often. People resist having a group home established in their community, yet once it's established, fear and prejudice disappear because people realize that the mentally ill people are good neighbors. Druid Hills Presbyterian Church and St. John's Lutheran Church, both in Atlanta, are other examples. These churches have had worship services for homeless people, many of whom have been mentally ill for years. And both churches try to bring healing to people's lives in other ways. In a program at St. John's called Joshua Ministries, a woman offers her home. She provides a loving and caring family environment for anyone who comes, and they pay what they can. Druid Hills has art classes and other activities that help people with mental illnesses feel some self-worth and creativity. Nothing is more important to

a person who is suffering from mental illness.

Finally, churches need to think about their roles as advocates. Mentally ill people are one of our truly powerless constituencies. They don't write letters to their state representatives or their newspapers; they don't picket and demonstrate in front of state capitols; there are not enough advocates on their behalf. It's easy for us to forget about them and their needs. When we look at this problem in spiritual terms, we have to be affected by the need. If we see as part of our mission the advocacy of those who are poor and powerless, then advocacy for mentally ill people will become a major concern for churches and religious organizations. Churches and congregations need to take on the task not only of caring for these people in need but of proclaiming their cause.

People with mental problems are our neighbors. They are members of our congregations, members of our families; they are everywhere in this country. If we ignore their cries for help, we will be continuing to participate in the anguish from which those cries for help come. A problem of this magnitude will not go away. Because it will not go away, and because of our spiritual commitments, we are compelled to take action. ☸

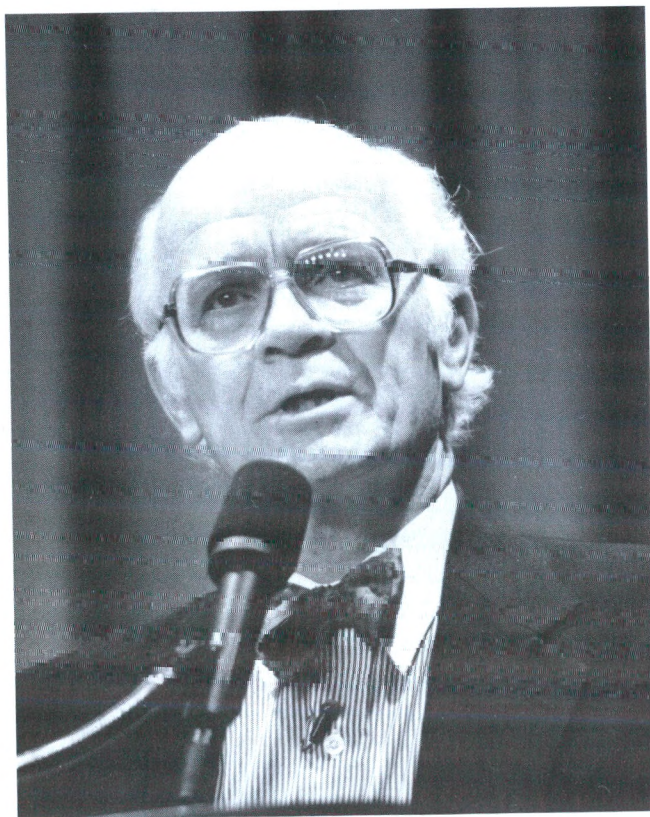
I would like to offer some practical suggestions in the context of Matthew 25. "Then the holy one shall say to the people on the right, 'You who were blessed by my maker, come and receive the birthright which has been prepared for you since the creation of the world. I was deaf, and you provided sign language interpreters. I was hearing-impaired, and you provided assistive listening devices. I had a child with Down's syndrome, and you asked my whole family to serve as greeters. I was in a wheelchair, and you made a way for me to approach the communion table. I was schizophrenic, and you welcomed my sharing in your prayer group. I was vision-impaired, and you bought an enlarging copier machine. I was a recovering alcoholic, and you entrusted me with responsibility. I had AIDS, and you gave me a place to live. I had no voice, and you gave me a funded conference task force. . . . I tell you indeed, whenever you did this for one of the least of these brothers and sisters, you did it for me.' "

—Holly Elliott,
a conference participant



The Tradition of the Church in Health and Healing

Martin E. Marty



God, or the language about God, is the subject of theology. What the people of God believe it is that is handed over (*traditum*) to them through the generations makes up the tradition of the Church. This tradition includes their persistent striving toward fullness of life. True fullness, in biblical language, belongs to God alone; to Christ as embodiment of God (Colossians 1:19); in one case—perhaps—to the Church as the body of Christ (Ephesians 1:22–23); and derivatively to all that the earth contains (Psalm 24:1). At the same time, believers may themselves move *toward* being “filled with all the fullness of God” (Ephesians 3:19) and measured by “the stature of the fullness of Christ” (Ephesians 4:13).

What bearing do Christian traditions and theologies have on health? In this brief compass it would be foolish even to attempt to sample their *content*: the *World Christian Encyclopedia* (Barrett 1982:15) speaks of seven “major blocs,” 156 “major ecclesiastical traditions,” and 22,190 presumably major “denominations.” Instead I wish first to describe a *challenge* to Christian action and expressions that is put forward by contemporary preoccupations with health and healing and then to point to some of the ways believers can draw upon theology and tradition, especially in North America.

The focus on “striving for fullness of life” narrows to another still immense subject: how does this striving

relate to *health and healing* through response to the grace of a fulfilling God? The thesaurus reminds us of the challenge in classic terms by posing the opposites to *health*: sickness, illness, disease, ailment, weakness, debility, infirmity, and frailty as part of the human condition. It also lists the antonyms to *healing*: wounding, hurting, injuring, harming, breaking, making worse, getting worse. These simple words call to mind the ageless passion and drama of life, the endless tears and blood, the ceaseless cries of pain or dereliction, also by people of faith. The theology and tradition of the Church address these negatives even as they speak positively of the presence of health and healing or of the search for them.

If sickness and frailty are classic challenges, contemporary life has its own approach to them. For a generation an increasing number of North Americans, some of them disillusioned with scientific medicine and conventional care, have striven for "fullness" or "wholeness" through what has come to be called the "holistic health movement." This movement has made the major news on that front where theology and church traditions face their temptations and opportunities. It was born in countercultures but now has found its place in the mainstream as well (Alster 1989:5). One critic has offered these definitions:

Holist: Minimally, someone who subscribes to the thesis that an organic whole is more than the sum of its parts, and who rejects mind/body dualism.

Holistic health care: A system of health care predicated on the above. Advocates of holistic care may agree on these ideas and very little else. Practices range from the exotic to the conventional; practitioners from the suspect to those licensed as professionals. (Alster 1989:47-48)

An advocate, R. H. Svihus, provided further definition:

Holistic health, then, is a state of integration of the physical body and of the mental and emotional soul-self, in harmony with the spiritual self. . . . The concept refers to the fact that the whole of a person is greater than the mere sum of his parts, and that there is an approach to the whole person who is ill, instead of merely to his parts or to his illness as if they were separate from the whole of him. (Svihus 1979:480-81)

Abraham Maslow (1970:xi), a champion, elaborated: "Holism is obviously true—after all, the cosmos is one and interrelated; any society is one and interrelated; any person is one and interrelated, etc."

One popular holist, Rosalyn Bruyere, spoke for most in the movement when she referred to the "energy" which forms the *connection*—a key word—between all things: "for me, the terms *God* and *energy* are interchangeable. God is all there is, and energy is all there is, and I can't separate the two" (Nietzke 1979:31). The challenge to Christian theology and tradition in such expression is obvious, but so is the lure. Christian faith,

However much Christians have to learn from some features of holism, they cannot deliver on the holistic promise (which holisms also cannot do.)

also an energy system, strives for fullness and sees that somehow in Christ all things are connected. Believers who wish to address the needs of their time have therefore been tempted to show that they are relevant to the holistic movement and have something to offer in its market. While bibliographies on Christian self-help books show evidences of restraint (see Chase 1985), the books, conferences, and counseling techniques advocating Christian holism or holistic Christianity have become numerous, and the language of the movement has penetrated ordinary Christian discourse on health and healing.

This may, however, be a late and inopportune moment to jump on the bandwagon to the holistic market. For although that market remains huge, the beginnings of systematic critique are having an effect. Critics come from across the spectrum, which includes evangelical theologians (Reisser, Reisser, and Weldon 1983) and medical practitioners (Alster 1989) alike.

At this moment of reaction and criticism, Christians have an opportunity to separate their theology and tradition—if they know these—from holistic ones, and then to offer their own particular gifts. On the other hand, succumbing to holism's temptation could be devastating. However much they have to learn from some features of holism, Christians would remain disadvantaged in the competition, since they cannot deliver on the holistic promise (which holisms also cannot do). They would fail in the face of inevitable suffering and death. They would be engaging in false advertising

because at heart their approach is incompatible with this promise. They would also alienate chastened and reformed scientific or medical professional communities at a moment of considerable opportunity for better interactions with them. They would likely further compromise the passion for justice in delivery of health care, which is already waning enough in most Christian circles. And when the wind and spirit of the time, the *Zeitgeist*, shifts, they will be left behind, only more distant than before from their own not inconsiderable resources.

Christians, then, should not be surprised or put off by the beginnings of disillusionment over assured "wholeness" as a reward for human striving. Much extravagant holistic language refers to the self as God because of the connectedness of everything. Biblical language consistently stresses the partiality of creaturehood: we are not gods, not God; God alone is God, and God alone perfects wholeness and fullness. The believer always has to say, "Now I know in part" (1 Corinthians 13:12). What I do to live with that partial realizing of fullness in a world of illness and of "getting worse" makes up much of the drama of lived and storied existence.

Wholeness, Fullness, and "Some-ness"

Let me set against Christian alliances with holism the simple-sounding concept of "some-ness" voiced by American philosopher William James. We can wrest the

concept from the Jamesian context of “radical empiricism and pluralism” and show how it is faithful to common sense and Christian expression as well. In the face of contemporary gnosticisms, New Age concepts of the connectedness of everything, nostrums, and distorted Christian expressions, what he takes from empiricism and pluralism is helpful here. Over against simple holism, James says, this alternative would “stand out for the legitimacy of the notion of *some*: each part of the world is in some ways connected, in some other ways not connected with its other parts, and the ways can be discriminated, for many of them are obvious, and their differences are obvious to view” (James 1977:40–41).

Obsessive striving for fullness of life and wholeness of being stresses only the connected aspects. But the unconnected parts are also manifest in a world where finitude, contingency, and transience set limits on effective striving. We have limits, accidents will happen, everything passes, we will die. To the eye of faith, of course, there is an invisible, final, and complete connecting. Thus for the Christian, “all things hold together in Christ” (Colossians 1:17). But in the empirical world, in space and time this side of death, the “not connected,” partial, and broken elements remain to cast their shadows over all striving. To avoid and evade them is to trivialize the Christian faith.

For experts, whether in professions relating to physical health and healing or to spiritual and theological counterparts, a word of Paul Tillich poses the problem. Already in 1961 he spoke of both the promise of fullness

In considering the process of healing and how it fits in with a religious standpoint, we face an ancient religious question: If God makes somebody sick, who are we to interfere? How can we intervene in God's will by curing, if God made ill? . . . Maimonides says that the basis of the permission to interfere is the commandment in Deuteronomy to restore a lost object. It's repeated more than once in the Bible. If you find money, fruit, a book that belongs to somebody else, you can't just wait for him to come and claim it. You've got to announce it actively, aggressively, go about in the marketplace and say, "I have found a lost object. Whoever can identify it please come and get it." That is a mitzvah, a commandment, to restore lost objects. A whole volume in the Talmud describes how to fulfill the mitzvah. Maimonides says that's how we know the doctor may and must heal. He is restoring lost health. If a person has lost his health, the doctor, nurse, and medical staff with the necessary skills are able to retrieve what he has lost, and therefore they have an obligation to do so.

—Rabbi David Feldman,
Teaneck Jewish Center

Biblical language consistently stresses the partiality of creaturehood: we are not gods, not God; God alone is God, and God alone perfects wholeness and fullness.

and the human limits experienced in efforts to address it: "In order to speak of health one must speak of all dimensions of life which are united in [the human]. And no one can be an expert in all of them" (1961:92). More recently physicians have spoken in criticism when people have acted without remembering what Tillich's second sentence signals. A letter to the editor of the *Journal of the American Medical Association* by Dr. O. P. Friedlieb in 1979 was an early warning signal to those who made unreasonable demands on physicians and others who give care:

Where in the name of everything holy does it say that a physician is to be more than a healer of sickness? . . . Why in the world are we expected to be all things to all people and take care of all of everyone's problems? . . . Certainly no one expects a clergyman to do appendectomies or a sociologist to treat acute glomerulonephritis. (Friedlieb 1979:1490)

And with the patient in mind, others ask:

Does not this definition of health in terms of well-being lead to an unrealistic expansion of the obligations that providers have in delivering health care to their clients? . . . Perhaps the clients do not care to discuss or be counselled about their. . . family, habits, mode of living, and philosophical or religious convictions. What qualifies the health practitioner as a counselor in moral matters about how

others ought to live their lives? (Kopelman and Moskop 1981:213, 226)

It may seem defeatist for the cause of a striving for "fullness" to respond in sympathy to the rage and anguish of Dr. Friedlieb or to the boundaries set by authors Kopelman and Moskop. Yet realism and strategy must surely lead one to agree that neither the physician nor the member of any other profession (including the clergy) nor follower of any other vocation can heal everything or be all things to all people. Such assent might appear as capitulation to an often destructive feature of modernity—the differentiation (Cuddihy 1974:10) of life into specializations, into pieces, which can work against the good of patients, sufferers, victims, or even physically healthy strivers.

Yet in the spirit of William James, this willingness to "stand out for the legitimacy of the notion of *some*" can help provide a renewed charter for the Church. The Church believes in the ultimate and invisible connection of everything with God's wholeness and Christ's fullness—but it overreaches when it claims to realize these fully or advertises that they can and must be thus realized in the here and now. The Church points to what the minister, chaplain, theologian, or churchly agent for mercy or justice can offer alongside medical practitioners, researchers, and secular counselors who also contribute their *some* in an enormously complex scene.

Kristine Beyerman Alster, who has reacted against the holistic health movement at length, asks at her book's

end, in the spirit of William James and the Paul of 1 Corinthians 13: "Could it be that the [holistic health] movement would achieve more success by reducing its ambitions? Rather than claiming the ultimate perspective for dealing with issues of health, it could more modestly suggest that it is one of several useful perspectives" (Alster 1989:181).¹

In practical and empirical life, Christian faith as interpreted in theology and lived in tradition could also achieve more by recalling the partiality of its claims. In realizing its part, its perspective, the Church faces its challenge; it can then bring its gift and revise its agenda and mission.

In noting the current reaction against the exaggerations of the holistic movement and recalling the older recognition of limits in all professions and perspectives, we may be passing too quickly over a longer-term trend: the return of faith to the scene. It may seem to some that it is premature and futile to gear up for a course correction when a vehicle itself is only getting launched. Some in the Church, many in the scientific culture, and most in the culture of patients have not yet realized the influence of holistic health interests, including those of a religious nature. I refer now to movements and events which, late in this century in times that some call postsecular or postmodern, have seen the bringing back of faith and the interpretation of belief to legitimate roles in the striving for health and healing.

Alongside the medicine, pharmacy, exercise, research, and economic interests that address physical ill-

Often when we speak of healing we speak of faith and healing. In the New Testament stories we find that it was not only the power of Christ that healed the sick but often more the power of faith. In Islam, which means faith in and submission to the will of the one and only God, faith becomes itself a source of healing.

—Dr. Mahmaud Ayoub,
Department of Religion,
Temple University

Healing must begin in the soul. One of the greatest diseases described in the Qu'ran is despair; therefore God says, "Oh, my servants who have been too harsh with your souls, with yourselves, despair not of the mercy of God for God forgives all sins."

—Dr. Mahmaud Ayoub

Academic ethicists know that in times of crises they are not alone convoked; patients also ask, “What does God say?”

ness, people seek, as they have always sought, some resources for dealing with the mental, moral, spiritual, intellectual, experiential, and affective concerns related to health and healing. Most people will draw on anything they find effective in this second and parallel quest, whether it be faith healing, philosophical probing, or religious faith. In recent decades if not centuries the public had found this pursuit to be widely discouraged and profoundly frustrated. In sociologist Peter Berger's terms, the “reality policemen” who decided what was allowed to be believed too readily wielded heavy nightsticks to discipline the believers. So the public was obliged, as Berger once put it, to smuggle in the gods, who, “as it were, come in plain brown wrappers” (1974:1221).

The reality policemen were not always so brutal and forbidding as there described. They were often only the benign guardians of other *some's* of which William James spoke. Never did all their colleagues neglect or oppose faith when presenting their version of an all. However, what had developed and often remains strong, sometimes as a belligerent force and often quite casually, was an ethos that left no place for theology, the tradition of the Church, or the resources of faith. Most people called what resulted a “secular” culture. In some respects and from some perspectives, it is that. But it is not and never was simply or utterly secular. George Gallup (Gallup and Jones 1989) and a hundred other pollsters and survey researchers turn up consistent evidence that the same culture, in ethicist William F. May's memorable words, fairly “reeks of religion.” How do we deal with that?

The Limits of a Liberal Culture

One way to begin fresh thinking is by renaming the culture and then seeing how and why religion finds a place in it. A helpful attempt is political scientist Robert Booth Fowler's characterization of ours as not a secular but a “liberal” culture. Most believers have also simply walked into it. They know it provides the environment for contemporary medicine, research, and most care. Fowler does not mean that ours is a politically or theologically liberal culture in the usual sense of the term—the “L” word was supposed to have been “out” in politics as recently as 1988. Instead the liberal mode refers to three things:

- 1) a commitment to skeptical reason, an affirmation of pragmatic intelligence, and an uneasiness about both abstract philosophical thinking and nonrational modes of knowledge; 2) enthusiasm in principle (and increasingly in practice) for tolerance not only in political terms but much more obviously in terms of lifestyle and social norms; 3) affirmation of the central importance of the individual and individual freedom.

Fowler argues, and I concur, meanwhile, that

religion in America has been, and continues to be, an *alternative* to the liberal order, a *refuge* from our society and its pervasive values. Yet, by providing that space from our liberal order, it unintentionally *helps* the liberal world. (Fowler 1989:4)

The last sentence should disturb believers when they are in their roles as prophets of faith or purists, but that is not our present concern. What is important is that we would not have the benefits of modern research and medicine, mixed though they be; we could not enjoy the life of a republic, ambiguous though its boons are; we could not experience the freedoms we know, bounded though they be, were it not for the development of this liberal culture. One can see its positives as gifts of a provident God and at the same time criticize its negatives. Or at least this critic can comment on its merely partial perspectives, which some persist in seeing as its “wholes,” when these are associated with arrogance, pride, blindness, and in some aspects even the demonic.

However we characterize and judge it, this liberal culture provides the intellectual ozone we all breathe, the spiritual envelope which enwraps us—unless we do something about it. Most citizens, as the evidence of the polls and our eyes overwhelmingly suggests, *do* “do something about it.” Even if superficially and half-heartedly (but often strenuously) they turn to their faith to provide *alternatives* where liberalism is unsatisfying. They also sometimes turn to church (or synagogue or mosque or other holy place) as *refuge* from this culture—not necessarily for mere escape but as when an army retreats to prepare for other encounters. And in faith-centered gatherings contemporaries go on to find or build the *community* which the individualist culture largely fails to provide.

We can't say that there is a God of good and a God of evil. All of it comes from one source; there is one God who does the good and evil. But whereas there is one God, we have an ethical imperative to help bring the world closer to what the goodness of God wants, namely, that there be healing. So healing is our mitzvah, and that's why we restore the lost object. You couldn't observe any of the commandments if you had a passive theology that said "I won't interfere." On the contrary, you may and therefore you must intervene.

—Rabbi David Feldman,
Teaneck Jewish Center

The medical ethics committee on which I serve extended the unconditional mandate to heal and applied it to infertility as well. Blue Cross/Blue Shield says that a woman's inability to conceive is not an illness and that it won't pay for assistance with in vitro fertilization. But we've determined that infertility, barrenness, is as bad as any other pathological condition. It too is a part of the mandate to heal.

—Rabbi David Feldman

For the Christian, “all things hold together in Christ.” But in the empirical world, in space and time this side of death, the “not connected,” partial, and broken elements remain to cast their shadows over all striving.

The liberal culture, of course, remains enveloping, while the believing community, as Fowler also contends, goes about making bargains with it which help that community survive. The government, on constitutional grounds, cannot provide theological alternatives or refuges. The traditions of the mass media in a pluralist society do not match the traditions of any of the church traditions. Public education on all levels engenders or licenses a community of inquiry but not of explicit religious faith. The corporate, business, advertising, and commercial worlds form a context of skepticism, toleration, and individualism which levels, excludes, or finds irrelevant all religious faith. The practices of the laboratory and the clinic similarly overlook or violate the claims made on a part of life by church traditions. Many fashion religions or quasi-religions out of one or another or all of these liberal culture zones; each is capable of attracting idolatry. But they also offer potential benefits which believers enjoy and recognize, and which even the most critical or prophetic of them rarely wishes to escape. Even the philosopher gets a toothache, says Shakespeare, and even the Christian critic of technical medicine wants anesthetic and high-speed dental drills when his pain or her infirmity is being treated.

The acts of addressing what it is that faith approaches, as a refuge from this liberal culture or as its alternative, occur on many levels. Inevitably, individualism operates here, too. No one cares more than the sufferers themselves to find or fabricate systems of meaning, to glimpse parts of the whole, to know something of the

fullness of life as it is realized in health and healing. Yet more than most of us realize, these systems of meaning come partly prefabricated, and they are borne by communities. We call one of these the Church. Its meanings come as part of the Christian tradition or traditions.

The New Turn to the Fullness of Life in Faith

Following the news of holistic medicine, then, we have been hearing reaction to its extravagant claims and demands. Even earlier, though, people in our time were finding ways to be religious—and in matters concerning health and healing—in spite of a partly uncongenial culture. If the present moment provides a challenge that represents both threat and opportunity to the churches, it is time to bring the issues into focus. Why, and why *now*, are thoughtful people making faith, theology, and Church tradition a part of their religious alternative and refuge? We shall speak of tradition in this temporal context.

The Dutch historian G. J. Renier (1950:14) says that most of the time we pay no conscious heed to what archivists, chroniclers, and historians do. These professionals find, collect, keep, protect, and expound the elements of tradition of which they are custodians. The rest of us pay attention only at special times, when we “stop to think.” Stopping to think becomes thus an almost technical term, and it well describes what has been going on in the very recent past.

Seekers and strivers in our culture have "stopped to think" about what skeptical reason by itself does *not* provide in the search for health and healing. They examine what toleration based on or productive of indifference in a pluralist society does *not* do to bring specific meanings to specific people with specific needs. They reach for what individualism and privatism do *not* do for people who welcome and would offer communal support in times of illness, frailty, or "getting worse."

Leszek Kolakowski, a Polish ex-Marxist philosopher who now lives in the United States, has dealt with *myth* as a category which here corresponds to the faith-centered quest. He also describes our betwixt time, the days when "some-ness" and *alternatives* and *refuge* are vital. Thus: "We cannot now imagine a return to myths which could effectively reinstate a hierocratic [clerically ruled] despotism over secular life. But neither can we imagine a culture totally bereft of mythological [read also: religious] elements." Kolakowski continues: "The principles of existence between mythology [read also: religion] and a scientifically controlled civilization will undoubtedly be worked out over a long period marked by tensions and clashes." We know much already about these conflicts in the spheres of medicine and science. Kolakowski goes further in dealing with the betwixt world: if mythologies (or faiths) "do not wish either to advocate flight from the world or theocracy, there are still other ways in which they can question all the realities of immediate experience: by demonstrating the non-self-sufficiency of such realities. . . ." Relevant to

There is in the Qu'ran a passage which parallels in some way the dramatic passage in Matthew 25, where righteousness is attributed by God and Christ to those who visit the sick, feed the hungry, clothe the naked, care for the prisoners, and so on. Muslims have often argued about the exact direction for prayer, and this has sometimes taken precedence over more important issues. Hence, the Qu'ran says, "It is not righteousness that you turn your faces toward the east and the west. Righteousness is this: that you have faith in God, in his angels, his scriptures, his prophets, and the last day, and that you give of your wealth, even though you may cherish it, to the poor, the destitute and the needy, the orphaned, and for the ransoming of war captives. And that you fulfill your covenants when you make them and you be steadfast and patient in times of adversity and in times of hardship." This admonition to be patient and steadfast and to strengthen one's faith in time of suffering and adversity could lead as it has in many Muslim countries today to a glib acceptance of death, which in the end means the trivialization of human life. But that is not what Islam

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Neither the physician nor the member of any other profession (including the clergy) nor follower of any other vocation can heal everything or be all things to all people.

our purposes among these are “their inability to create independently those values thanks to which human communities are able to survive, their failure at self-interpretation, and their failure to produce by their own strength principles of understanding the world in addition to rules for manipulating objects” (1989:107-8).

The Church through its tradition and theology *does* intend to be among those forces that build communities of values, offer sustaining interpretations, and seek healing sets of meaning in the face of suffering. The manipulating of objects—whether these are the artifacts of the medical world or the patients as impersonal objects themselves—is not satisfying. Kolakowski thus joins James and Fowler in helping provide elements which we can hear as part of the challenge to the Church. There is room for its gifts alongside those of others.

The Faith Dimension and Its Reaches

The faith dimension has returned to the fields of health and healing in a number of ways. When medical ethics, or bioethics, was first born it was at home in theological communities, where many of the pioneers worked. Quickly it moved from them into the directly liberal culture of the university and clinic. There it provides a marvelous but incomplete set of approaches to health and healing, *some* response, in the Jamesian sense. Academic ethicists know that in times of crises they are not alone convoked; patients also ask, “What does God

say?” as mediated through their ministers, their tribe with its traditions, their family and friends, their souls’ experience. At such times one hears Aristotle or Hippocrates on proportionateness or nonmaleficence cited less frequently than one hears “thus saith the Lord” or “the love of Christ controls us” or “my pastor says,” within the large Christian subculture, or analogues to such language in Jewish, Islamic, Native American, Asian, and other subcommunities.

Second, the liberal culture offers only *some* connected but partial sets of *meanings* for those who would cope with suffering. Yet these are manifestly not self-sufficient or satisfying understandings for other dimensions of life. Most people draw on faith and faith traditions when seeking to overcome emptiness or brokenness while they strive toward some measure of fullness and wholeness.

Third, the tradition is or can be embodied in the *action* of faith communities, which provide intercession, casseroles, caucuses working for justice, agencies to inspire volunteerism, nursing aid, concern for the aged, and long-term care, where the liberal culture often runs out of resources or patience. While writing a book on my own part of the faith tradition, I asked a presiding bishop what advice he would give to someone who had just heard she had a terminal illness. He answered, “She should have been an active participant in a good congregation of believers for the previous twenty years.” He spoke in language distant from holism’s; there was no quick fix, and one had often to “tough it out,” he

said, but he pointed to what those in the tradition know: that somehow community is part of the striving for fullness (Marty 1983:170).

Tradition and Its Roots in Story

It is apparent that the Church tradition, born of faith, expresses itself both as interpretation, especially of suffering, and as community, especially for care. Indeed, interpretation is necessary chiefly because there is and will continue to be suffering. The Church draws its challenges from the need both to interpret and to provide community. So we must connect theology, the language and act of interpreting the life of the people of God in the light of God, with tradition, that which has been handed down and is being passed ahead in the community. This is both a difficult and an urgent task.

It is difficult because tradition, the tradition, and traditions, in the Christian instance (as in the Jewish and Muslim cases), are rooted in story. They do not come spontaneously, automatically, from internal resources, as they do in the “connectedness” of holisms. It has become almost a cliché to speak of the narrative or storied element in Christian—as in Jewish or Muslim—faith, but this element cannot be denied. It demands constant inquiry, attention, and affirmation. There are mythic elements to the story, but it is not pure myth or archetype: it recalls, celebrates, and reenacts God’s word, happenings, and events in the world of God’s people. Some elements in this story can be capably ad-

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understands by health and healing and by accepting death when it comes. Rather, as God created the world, and in his mercy looks after the affairs of his creatures, so must we in accordance with the prophetic injunction “show mercy to those on earth so that he who is in heaven may show mercy toward you.”

—Dr. Mahmaud Ayoub,
Department of Religion,
Temple University

The Spirit of God within us is life, but life with dignity. For as God is holy and worthy of veneration, so must also life be holy and respected. The spirit of God in us is a spirit of righteousness, of holiness, of wholesomeness—a spirit that we cannot defile.

—Dr. Mahmaud Ayoub

The Church believes in the ultimate and invisible connection of everything with God's wholeness and Christ's fullness—but it overreaches when it claims to realize these fully in the here and now.

dressed by philosophy through propositions, critical inquiry, and the formation of dogma. But the tradition is story before it is principle. The specifically Christian story, as rooted in the Hebrew Scriptures and the New Testament Gospels, takes the form of what Paul Ricoeur (1984:208) calls “narrative emplotment.” This plotting comes to life in the call to faith through which later generations become part of the story. The counseled patient in a sophisticated hospital today connects with the ancient stories of Job, the Gospel narratives of a healed and grateful leper, or the parable of sheep needing a compassionate shepherd. Christian counselors offer narratives, even if sometimes these also take the form of prayers or confessions of faith. These are God-centered stories which resist the “manipulating of objects” and testify to the importance of persons, including the “least” of them, in their needs and strivings.

Here, in contemporary North America, in the midst of a secular, scientific, pluralist, liberal culture, serious people have been recovering confidence in the roots of a faith whose story shows it to have been born also as a movement of healing and health. Thomas Clarke, S.J., speaks out of the Catholic tradition: “The central thrust of [Jesus’] exercise of power is conceived as liberation from Satan, healing and restoration to health, and wholeness of human beings in the totality of their lives, physical and moral, social and institutional” (1980:259).

Some of all that is evident in the concern of Christians to interpret the cycle and passages of human biological life: conception, birth, aging, death. It is also

present when they work for better allocation of health resources or for the sustaining of sufferers both in their own community and in the circle of need beyond it.

Realizing and Employing the Tradition

But how vivid, available, and useful, really, are the traditions of Church and faith? They are not transmitted by believers through the genes, though in stable cultures they once seemed to be, protected as they were within territories and parishes. Thus historian Edmund Morgan (1966:182) has spoken of the American Puritan ideal of having godliness transmitted from the loins of godly parents to their children. Genes may have much to do with destiny, but they do not transmit story. Of course, traditions do get transmitted orally, by gesture, or by practice. This we see in Native American cultures where there was long no reliance on literacy, as well as in other complex cultures even today. Tradition is passed on in phrases: “This is what we do around here.” “That isn’t done here.” “In our family we always . . .” “The sages say . . .” “Our church never thinks of it that way. . . .” But these powerful oral and gestural transmissions need constant purification and clarification.

For these tasks, texts play their part. The Hebrew Scriptures, the New Testament, the writings of believers through the ages, written theology, the version of tradition we call history—all have their roles. But the intimate

and half-broken family circle is relatively inattentive to these. Public elementary and secondary schools almost entirely neglect them, even though it is legal to include them naturally in curricula. Higher education treats them, but only marginally and in isolating contexts. Mass media have nothing to do with them except as occasional curiosities or complicators: "This strange medical practice survives in this family because they are Mormons." Meanwhile the government must treat all religion and religions with what once entered the Supreme Court record as "wholesome neutrality," which is no way to make a tradition engaging or compelling. The modern clinic levels and reduces specific faith concerns or attends to them in specialized ways alone, as in chapels or by chaplains. Commerce shuns religious tradition.

The church to date has in conscious ways done far less with what was handed down than one might have expected. The Park Ridge Center for the Study of Health, Faith, and Ethics has commissioned over a score of volumes on health and medicine in various Christian and other traditions (Islamic, Jewish, Native American, and so on). In almost all cases, the authors reported that theirs turned out to be a lonely and often the very first act of gathering such resources of their traditions. Theological libraries contain tens of thousands of volumes, but in the age of skeptical reason, indifferencist toleration, and individualism, few authors or readers had been paying attention to the resources in the texts of faith traditions. That situation is changing

Recently in northwestern Oklahoma I saw a cedar tree silhouetted against the horizon, and not far from it, a satellite dish. According to our oral traditions as Cheyenne people, cedar from that particular tree when harvested and dried in a certain way can be used for ceremonial purposes and for healing. The cedar tree represents the Indian world, the Native American world; the satellite dish represents our scientific and highly technological world. Native Americans, who are somewhat distinctive, live within both worlds. They must in order to have health and well-being. But sometimes these worlds are in conflict. Alexander Solzhenitsyn has said, "To destroy a people, you first sever their roots." I think that's what's been happening to Native Americans. They have the highest morbidity and mortality rates of any group of citizens in our nation. Their roots are and have been severed.

—Lawrence Hart, Indian Ministries Task Force,
Joint Strategy and Action Committee

The Church through its tradition and theology does intend to be among those forces that build communities of values, offer sustaining interpretations, and seek meaning in the face of suffering.

suddenly, in theological schools, in history departments, in clinical settings and other places of healing. The challenge is to use what is there already and to find and produce more.

People do not ordinarily strive for health and healing, for the fullness of life, by going to the library and reading specialized books on faith traditions. They have lives to live. Yet elites, care givers, women and men who practice counseling and in some cases medicine itself, prophets seeking justice, physicians who promote healing—all have reason to be aware of how theology and tradition inform what they are doing. We may not all professionally devote ourselves to this one specialty alongside doing appendectomies, treating acute glomerulonephritis, engaging in basic research, providing pastoral care, discussing either “philosophical or religious convictions,” or counseling people about forming habits and adopting modes of living that promote *some* well-being. But the Church can promote self-consciousness about what goes on in all these conscious enactments, in order to serve the story better and to be better served by it. I have reported here on some recoveries, but how might they work in respect to tradition? This question can be approached through six terms using the prefix *re-*, indicating restorations that project into promising futures.

Six Elements in Recovery and Projection

One speaks thus to a Church that would meet challenges:

First, you have to remember elements from the tradition. The theology and informed practices of the Church begin in *remembrance*. Mnemosyne, Memory, mother of all the Muses, here moves from Athens to Jerusalem, from the realm of myth to the zone where she is patroness of story. The problems of recall, as our institutional review a moment ago suggests, are drastic. The tradition is born of and relies on remembrance. Yet many people are not in any conscious tradition, to say nothing of a faith tradition. Others were, but they now have amnesia, or they simply neglect to remember; they have therefore forgotten, as did their parents before them. Still others choose to forget, in a partly creative spirit of rejection. Why? Because the bearers of the *traditiones*, the introvertedly human participants in the tradition, are often repressive, ignorant, capable of “making worse”—dealers in death and not contributors to the “striving for fullness of life.”

Furthermore, in a pluralist and preoccupied society the tradition can become ever more vague, blurred, remote. We intuit that this or that belongs to Orthodox Judaism or Sunni Islam or Navajo life or Orthodoxy or Anglicanism, but it blends and shades into so many other ill-formed stories and theologies that it loses the

specificity one needs for healing and meaning. Simple and sometimes willful ignorance is common. Custodians of the tradition often show little imagination in helping it come alive in new generations. Mere remembrance plays tricks. The challenge is to move with it and beyond it. The tradition needs representation in lively forms.

Second, you have to look around and look deep for what to remember. *Reconnaissance* of theology and tradition follows. We think of reconnaissance as a search for knowledge of enemy terrain, but it is just as legitimate to see it as an act of becoming acquainted with anything unfamiliar, alien, foreign. Indeed, this foreignness can refer to one's own territory, which can be *terra incognita*. But reconnaissance also involves exploring the unfamiliar beyond one's own tribal boundaries. Many voices need to be heard: voices representing women and men, affluent and poor; those who work with high-tech medicine and those who would distribute basic care; who embody Catholic, Baptist, Lutheran, and many more parts of the traditions which grasp some of the whole Church tradition. As heirs of an inclusive and mature ecumenical movement, we hold up the mirror to ourselves and each other, and we open windows on elements of tradition that can enhance our personal remembrances when we necessarily "stop to think." Comparative history, the comparative study of tradition, provides perspective.

Third, after reconnaissance, you have to bring something back and project it into the future. *Retrieval* is

Our minds are still in the world of the cedar tree. Don't uproot us! Allow us to carry on our traditions. I'm tremendously impressed with the spirituality of Native Americans, particularly those who are the custodians of the sacred. I can read Psalm 24, and I can acknowledge that the earth is the Lord's and the fullness thereof, and all those who dwell therein. But those words become mere words for me when I consider our traditionalists. Before even beginning those prescriptions handed down by oral tradition, they first reach down and touch the earth and bring the earth up to themselves four times, the sacred number of our people. Only when they identify that they are part of God's sacred creation can they begin to speak or to carry forth those prescriptions for which they have custody.

—Lawrence Hart, Indian Ministries Task Force,
Joint Strategy and Action Committee

The faith tradition can be embodied in the action of faith communities, which provide intercession, casseroles, caucuses for justice, volunteerism, nursing aid, concern for the aged, and long-term care.

the next element in recovery and restoration of theology and Church tradition in the late-stage liberal culture. Catholic theologian Karl Rahner has spoken of a sort of selective retrieval, which implies the discovery and seizure of certain elements, *some* of the past, and the projecting of these into the present and for future (Carr 1977:258). It would be absurd to claim that just because something was in the original story or became a part of it through history it can be used to promote health and healing today. Many of the past practices and insights in the tradition, if put to work now, would contribute to death, not life. The contemporary critical Church community, engendered by the tradition, is selective even as it retrieves. The great Catholic student of tradition Yves Congar has written:

Saving faith is received by minds which must consider it not merely as something absolute, but as a deposit given once and for all by the apostles. . . . But, at the same time, these minds must "receive" faith in an active way, in a manner which befits their nature. They are human minds, discursive intellects which perceive successively and only partially; hence, also, minds fulfilling themselves only when in contact with other minds; lastly minds living in a cosmic biological and temporal continuum. Historicity is an essential characteristic of the human mind. (1966:256)

Hence the many conferences, sermons, classes, study sessions, "practical theology" engagements, and agen-

cies for justice and mercy which corporately select and retrieve "saving" and healing elements.

Fourth, you have to know in a special discerning way. *Recognition* is coming to be a technical term for this. Diana Culbertson (1989:9) has recently and simply defined it as "a kind of knowledge by which we apprehend meaning in a pattern of events or realize that the meaning we had once assigned to those events has been shattered." Simple cognition makes us aware intellectually of a fact or an idea, but recognition tells us what it implies and means. Perception deals with "part" of our being, while recognition "involves the whole of the perceiver's personal awareness, knowledge, values, and idea of existence." It is "the central humanizing and revelatory experience, the immediate cause of psychological and spiritual change."

The easiest way to vivify this dynamic for those Christians who know their story is to refer to the narrative of the disciples on the way to Emmaus with the stranger who expounded the scriptures to them (Luke 24). Then, in the performance of an act, there came recognition, when "he was known to them in the breaking of the bread." A revelation of the Resurrected Lord grasped and changed their whole being and brought them toward fullness of life. Judaism, Islam, and Native American life, let it be said, depend as fully on recognition as does Christianity.

But how does "revelation" through the theology and tradition of the Church relate to the search for healing and health? For most believers, the story begins with

what in faith they simply take as the self-disclosure of God. They also recognize that human genius, whether in the case of scriptural writers, saints, martyrs, activists, or theologians, promotes disclosure and contributes to "revelatory experience." We learn from past genius. We cannot mummify corpses today as well as did the Egyptians, cannot make violins as well as Stradivarius, cannot create as well as Shakespeare and Mozart; we *retrieve* what we can of their understandings and *recognize* in them special art.

Now, as Eugene Goodheart, cultural critic of a generation that repudiated traditions (such as Jewish-Christian), put it so well, the traditions "still possess us, if we do not possess them" (1973:9). People who have not done systematic work on what divine self-disclosure does for a modern believing physician who is on her own deathbed may still find that the tradition reaches them through the institutions of mercy, the acts of intercessory prayer, the rites of the church, the voices of children; those who keep alive the language of a compassionate healer who "cured many of their diseases, and plagues and evil spirits," and "bestowed sight" on many that were blind. Contemporaries still hear the command to go and tell what they have seen and heard: "the blind receive their sight, the lame walk, lepers are cleansed, and the deaf hear, the dead are raised up, the poor have good news preached to them" (Luke 7:21-22). In such stories, as heard and reenacted, they subsequently *recognize* where mere cognition did not satisfy, and such recognition can certainly inspire ethicists,

The Catholic health care system functions in the shadow of Jesus who, through his life, gave us an example of how to heal, to touch, and to bring the sick and suffering both to physical and spiritual well-being. Throughout the centuries the church's mission has been to create the human conditions where one can experience God, particularly in those moments of vulnerability and brokenness. The church's members and institutions collectively strive to respond as Christ would, by bringing to bear the support and concern of the community, by being a sign of God's presence, and by revealing that even suffering and death have meaning in the Christian perspective.

—Sister Kathleen Popko,
President, Sisters of Providence

Bearers of the faith traditions, the introvertedly human participants in the tradition, are often repressive, ignorant, capable of “making worse.”

theologians, and counselors in a postliberal or uncertainly liberal age.

Fifth, you have to draw on the living resources of tradition. *Ressourcement*, a term favored by Pius X (Dulles 1989:425) among others, bears on Congar's reminder that the tradition is not a dead pond, a past sufficiency. It is part of a “cosmic biological and temporal continuum,” which at least in *some* parts connects with the story which flows, as a stream, from the past and toward coherence in Christ and the prospect of fullness of life in God. One never can reinhabit the full context and sets of meanings of a past deposit to previous religious understandings of science or medical practice, to past statements on the subject, or even to contentment with the world behind or the world of the texts.

A contemporary classic statement of *ressourcement* in respect to theology, tradition, and text comes from Paul Ricoeur (1984:208). He points to three ways of approaching a text, each of which affects how people respond, whether as doctors and nurses, pastors and chaplains, planners and programmers, or patients. First one can look at the world *behind* the text: the prehistory, background, setting, and context that illumines it. Historians and biblical scholars professionally care about that. It provokes cognition but not necessarily recognition and thus is not fully a resource. Second, one can look at the world *of* the text. Literary critics do. It is important to know whether one is reading a pharmaceutical prescription, a description of surgeries, a parable,

a poem, a proclamation. To know this further promotes cognition.

Recognition, however, comes with the third world, the world *in front of* the text. In that world, story, language, and an “emplotted narrative” bring their horizons—about which I know something but beyond which I am beckoned to move—to my own horizon, which has a future not yet disclosed to me. Now I am bidden to make a resource out of the tradition by entertaining modes of thinking and acting and being that would be unthinkable were I not part of the community in which this text takes life, gives life.

This notion of *ressourcement*—the idea that the tradition may have more to say than it has said, that the Christian Church does not live off a tradition which only gets more remote, inert, and lifeless—is difficult but urgent to propagate and test. Instinctively people have a sense that a religious tradition is a City of the Dead, that theologians are keepers of that city and believers are survivors and relics; or, in Congar's term, that the faith is a deposit which, though not in his conception, has to be stewarded and hoarded. One illustration will suggest how *ressourcement* can work.

The context for the illustration will be not medical but moral. Throughout history, people who represent latencies in the tradition—for the support of human rights, or more specifically women's rights, or civil rights, or the rights of the oppressed—find their occasion to speak. Those who too readily criticize the Enlightenment or liberal culture neglect to notice that

often its representatives engendered ideologies of rights or produced polities which made room for rights *and then* these biblical and Christian latencies became patent and creative.

Thus Martin Luther King, as Max Weber would have it, fit the portrait not of the messianic or charismatic leader but of the virtuoso of a tradition. That is, he did not invent a new tradition any more than did biblical prophets did who called people to a covenant which was theirs but which they had not yet owned. A general movement provided the occasion. For example, civil rights were advanced in the Supreme Court decision *Brown v. Board of Education* in 1954 and thus technically assured by the courts and legislatures before Christian advocacy had reached the whole public. Then as a black Baptist and member of a Baptist and larger Christian community *and* of the liberal culture, King reached into two sets of resources.

Weber says that the charismatic leader views the tradition as follows: "It is written, but I say unto you." The virtuoso says, "It is written, and I insist" (Hill 1973:2). King "insisted" that the moral community claiming to be responsive to the Declaration of Independence and the Constitution was morally obliged to act on its philosophy and assurances, and some responded. He also appealed to the moral community that was responsive to the Scriptures and spoke to its conscience with "and I insist." There followed a moment of recognition, not mere cognition and, for a time, some consequent action.

The story of the Catholic health care ministry in the United States dates back to the American Revolution when women religious responded to the social needs of the day, caring for the wounded and responding to those suffering from epidemics. An extraordinary phase of institutional development occurred when religious pluralism did not greet the massive wave of nineteenth-century European immigrants. The Catholic immigrants' answer was to build schools and hospitals and social service agencies of every conceivable description. Daughters and sons of the immigrants entered religious life in great numbers, and their dedication and service made this system work. Parish churches served as centers of charitable outreach as early ethnic neighborhoods organized around them. The immigrant community shared its meager resources with the sick, the elderly, and the orphaned. Gradually there emerged a whole network of institutions to extend the ministry further into the community. This health care ministry has grown rapidly over the past hundred years, led in part by the congregations of religious women who have marshaled resources in service of the suffering persons.

—Sister Kathleen Popko,
President, Sisters of Providence

Christian faith is not a gnosticism which holds people responsible for self-transcendence over their own suffering, or an individualism which lets them be content with their own private “connectedness” to the All.

So it can be in the present moment with faith resources and the pursuits of health and healing. That there are impending if not immediate crises in the delivery of care ought to be obvious. The poor, the aged, the uninsurable “fall through the cracks” and have no safety nets or access. The cost of care in general threatens the economy of all and the well-being of the many tomorrow. Ethical problems associated with “skeptical reason” applied to scientific discovery are so abundant that they need no documentation here. The limits of meanings offered by liberal culture in the face of suffering call forth alternative responses. The virtuosos of the tradition will not say “but I say unto you . . .” if they wish to be responsible to the community and its members. They will say “and I insist,” and there is then a potential for astonishing, new, and fresh statement.

Recently I had occasion to draw on this feature by conflating something from the Dutch phenomenologist William A. Luijpen and Gershom Scholem. Luijpen had said: “Great thinkers are great to the extent that they see *already* what others do not see *as yet*” (Luijpen 1966:138).² The “great thinkers” may have names like Isaiah and Paul, Aquinas and Maimonides. Scholem, perhaps the greatest scholar of Jewish lore in this century, devoted his whole career to arcane and apparently irrelevant medieval Jewish mystical texts. An interviewer pursued the diffident scholar to find out whether he “believed” these texts, and what it was that drew his profound mind to devote decades to their study. Finally he exacted only this word from an impatient and

ironically dismissive Scholem: “There is one thing I know, and know beyond any doubt. The Kabbalists, the mystics, knew something that we do not know” (Steiner 1973:173–74). Put the two together: “The great ones of the past knew already what we do not yet know.” And healing potentially follows from our recognition of their resources.

Sixth, you have to respond, to make action concrete. *Response* comes from *respondere*, which meant “to promise in return.” It is the enactment of one who strives for fullness of life. Responding can mean, for instance, repenting of past ignorance or shortsightedness or even willful blindness in the face of others’ needs for health and healing. As philosopher Max Scheler puts it, repenting recognizes that in a sense there is no past except the one which lives through our present attitude to it. It asks not “Alas! what have I done?” and moves beyond “Alas! What kind of a person I am” to the fact that I *was* “such a person as *could* do that deed!” Then comes a transformation of outlook; “the continuous dynamic of Repentance enables us to glimpse the attainment of an altogether higher, ideal existence—the raising through firm self-revision of the whole plane of our moral existence” (Scheler 1970:46, 133; 1973:117).

This transformation does not mean that the Christian church any more than its tradition can be triumphalist, offering more than it can deliver by way of wholeness or fullness, as it is tempted to do in a market serviced and further created by the holistic movement and meanings. Christian faith is not a gnosticism which

holds people responsible for self-transcendence over their own suffering, or an individualism which lets them be content with their own private "connectedness" to the All.

I want finally to complement the original thesis about the limits of holism with one illustration from the Jewish and Christian traditions: the matter of suffering. Suffering is slighted by holistic traditions and by Christians who have drawn too close to its concept of connections and wholeness. One of the contributions by believers in these traditions in such a time as ours may be to retrieve, recognize, and make a resource of the meanings associated with the reality of suffering itself. The market for such realism and the hope that goes with it may be less promising than the holistic assurances which sidestep the issue or provide illusory ways of facing it. The recovery of Christian understandings of suffering can help motivate reaction against humanly caused suffering; it can further evoke measures of justice inspired by biblical mandates. But it also recognizes that the faith offers only *some* temporal and physical satisfaction, partial meanings and interpretations.

Leszek Kolakowski joins other contemporaries of vision and courage who chide the church for neglect and false advertising in precisely this sphere. He stresses one of the "important but little-noted aspects of our civilization . . . the complete departure from a belief in the value of suffering" (1989:88–89). Christianity in its approach to suffering, he says, "has retreated from our civilization to such an extent that even within Chris-

Before the Second Vatican Council, women religious staffed the country's health care and educational institutions in large numbers. Their presence assured that the tradition and values of the church undergirded the care in those institutions. The post-Vatican II understanding of religious life prompted many religious to redirect their energies from health care and education to other pressing social justice issues, from direct service to more of a sponsorship and governance role. Today in Catholic health care ministry the term mission effectiveness is used to describe the effort to insure continuation of the philosophy, tradition, and values of the sponsoring group and of the church. Such integration was taken for granted when large numbers of sisters were in those institutions.

—Sister Kathleen Popko,
President, Sisters of Providence

Supporting a cult of acceptant suffering and acquiescing to evil have nothing to do with biblical and Christian realism, action, and hope.

tianity itself it already seems either absent or meaningless." I doubt if that charge is true where Christianity is expanding, in sub-Saharan Africa, Latin America, and the subcontinent of Asia, among the oppressed and poor and suffering peoples, but it is devastatingly applicable amidst the promises of liberal culture. I want to identify with Kolakowski in his observation: "By its own behavior the Christianity of our own century bears witness so pervasively to the triumphs of its opponents." Thus "it is so fearful of Enlightenment criticism and so cowed by its strokes that it dare not, at least in open educational work, reveal many essential elements of its own traditional view of the world." As for connectedness and energy, wholeness and holism, we might apply his word: such Christianity "imagines in a euphoric vision an imminent ultimate reconciliation of the temporal world with God, abandoning the supremely Christian idea of permanent conflict between what is transient and what is infinite, and drawing a paradoxical view of the world, which in its very temporality will attain the value of an Absolute." Kolakowski does not call for "a cult of suffering so conceived that it turns into an indolent resignation, a cringing acceptance of one's own destitution, an assent to evil seen as inevitable and therefore surrounded with an empty halo of sublimity," all of which is "inimical to man." No matter what holists or Christians or anyone else does, suffering will always be sufficiently abundant that no one should make a cult of it or encourage wallowing in

it. But supporting a cult of acceptant suffering and acquiescing to evil have nothing to do with biblical and Christian realism, action, and hope.

Our present purpose is not to summon a critique of a liberal culture that is too consistently unmindful of the role of faith, theology, and Church tradition. Nor is it designed for a prolonged bewailing of the neglect of theology and tradition. It is not even content with individual or communal corporate repentance over the fact that we were "such a person or church that *could*" do such deeds of neglect, could fail to strive for the fullness of life for the self and others. The agenda instead is marked by the word *challenge*. Therefore it calls for a response to a "world in front of the text."

That world will not stop being scientific, secular, liberal, mindless of theology or church traditions, neglectful of or often hostile to the dimension of faith. It is one in which *alternatives* to, *refuges* from, assaults upon the hegemonies of, and critical corrections to these prevailing tendencies by thoughtful believers have a better chance of a hearing than had been the case for many decades. Whether there is a hearing depends upon how the Church meets the challenge—whether it has something to say and some visible things to do to promote the recognition that something revelatory is going on. This prospect would mean that healing and health are part of the story, the charter, and the promise of a faith born in the context of suffering and death, the suffering and death that do not have the last word. ☸

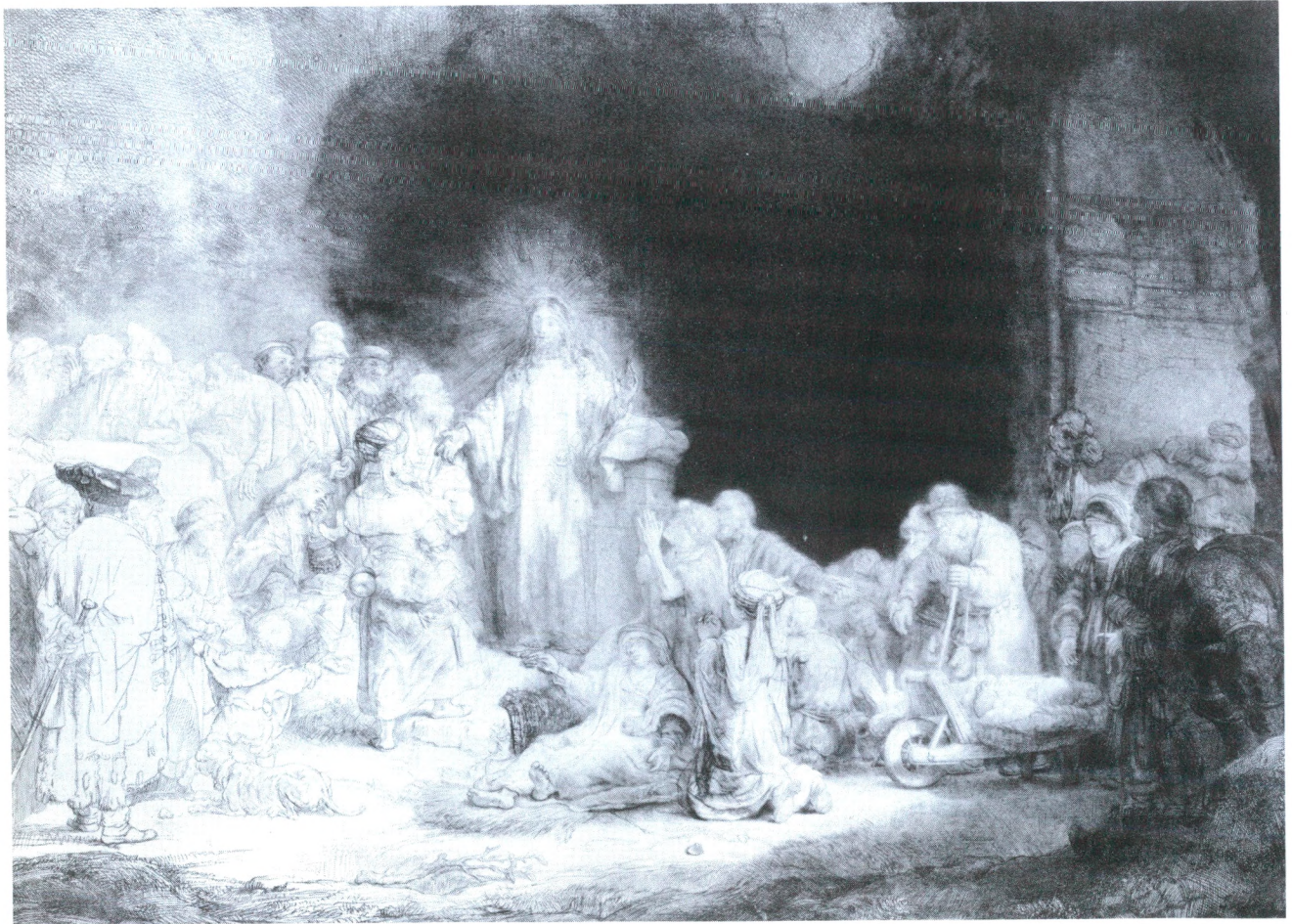
NOTES

1. Alster's critique of the holistic health movement gave me access to the arguments of Svihus, Maslow, James, Tillich, Friedlieb, and Kopelman and Moskop; it deserves extensive study.
2. I wish to acknowledge the part the 1989 Frank Roach Memorial Lecture at the Stritch School of Medicine at Loyola University in Chicago had in leading to my development of this and other themes in the present paper. Dr. Roach was a scientifically equipped physician and a humanist who left a mark on many in various fields of inquiry and service. He pointed us constantly to those who "knew already what we do not yet know." This essay is dedicated to his memory and is an attempt to help extend his influence.

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Christ Healing the Sick (*the Hundred Guilder Print*),
etching by Rembrandt, ca. 1649.

Philadelphia Museum of Art, William S. Pilling Collection

The Congregation as a Place of Healing

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Grace Lutheran Church, River Forest, Illinois, 1989.

Photo by Derek Olson

One Congregation's Experience

An Introduction

James P. Wind

As the Carter Center conference papers indicate, the challenge to our nation's churches, synagogues, and religious communities in the area of health is immense. Local religious communities can be so overwhelmed by the size and complexity of the agenda in this field that they succumb to the American temptation to do nothing. Fortunately, many of our churches and synagogues have decided to enter the fray rather than throw in the towel. In fact, so many are seriously engaged in so many different health-related ministries that

we have no adequate accounting of the overall contribution to public health currently being made by churches.

Depending upon how broadly or narrowly one defines *health* and *healing*, traditional social ministry activities like food pantries, housing projects, and visitation programs for the homebound may be included. But the efflorescence of more narrowly defined healing activities on the part of our nation's religious communities is also significant. These range from healing-centered worship services to church-run medical clinics and counseling centers. Our nation's congregations build facilities for their infirm elderly. They staff hospices and maintain innumerable support groups; they also offer members fitness and wellness programs. Given the diversity of programs and ministries already in

The Park Ridge Center wishes to express its gratitude to the people of Grace Lutheran Church, River Forest, Illinois, its pastor, the Reverend F. Dean Lueking, and the participants in this project for making possible this pilot study.

With the exception of groups that make conscious decisions to demodernize and enforce uniformity upon their members, the trend toward diversity of opinion is burgeoning.

existence, there seems no limit to what congregations can do to fulfill their mandates to heal.

Yet President Carter's challenge to close the gap between what we know we should do and what we actually do remains. The public and personal health needs of our nation quickly overshadow the many contributions already made by churches. If more is to be done and the resources of more religious communities are to be enlisted, several things must occur. Calls to action like those heard in the preceding articles must be sounded. And compelling examples of needs and practical responses must be offered. But more still is required. The imagination of our religious communities needs to be stirred and shaken. Congregations and synagogues must learn to think differently about their responsibilities for health and their roles in healing.

It is this latter task which the second half of this issue of *Second Opinion* addresses. The articles that follow invite readers to enter a parochial world, locus of a Park Ridge Center-sponsored two-year pilot study which sought, in the congregational setting, to advance our understandings of the relationship between faith traditions and modern health care. The Center turned to the congregation because discourse about faith traditions seemed most naturally to occur in church communities. To be sure, these traditions also surface in hospitals and professional schools, but they frequently remain veiled behind secular and professional languages and procedures.

Unlike conventional research projects, which are carried out in libraries and laboratories, this study was conducted in a church parlor where three groups of people carried on an unusual discourse. People with serious chronic illnesses, people in the midst of deep personal grief, and people who made their living as health care professionals were asked to talk about the relationship between their faith tradition and their experiences. Each session dealt with a fundamental human question: the meaning of personal suffering, the encounter with death, the experience of failure, the burdens of care, and the limits of responsibility. Individuals were asked to tell their own stories about such experiences and to describe how their faith tradition provided resources for such momentous encounters—or failed to. It became apparent as the project proceeded that the record was indeed mixed. At times people found direct and helpful connections between faith and life. At other times religion seemed unrelated and unconcerned, occasionally even a source of greater suffering. It also became apparent that both those who experience illness and loss and those who make daily professional pilgrimages through the corridors of our caring institutions had no regular place to search for these connections or to ponder the lack of them. It became clear that congregations could provide much needed space for a discourse that would address people's deep needs for meaning and personal reintegration. As the project developed a thesis emerged: congregations can participate in human healing by

offering new possibilities through imagination and fresh perspectives developed in the interaction between personal experience and faith traditions.

The particular congregation chosen was an established independent Lutheran congregation with approximately sixteen hundred members. The congregation has been a denominational leader in many forms of ministry, but this was its first corporate venture into the areas of chronic illness, grief, and medical ethics.

Congregations are seldom religious in general (even those espousing a universal stance have very particular roots, worldviews, and decorums), so the one entered here, Grace Lutheran Church, presents readers with a particular religious world (Lutheran), a particular socioeconomic location (upper-middle-class River Forest, Illinois), and a particular set of local traditions. That particularity is not held up here in a normative sense; nor are these articles attempts to convert people to a particular religious point of view. Rather, they delve deeply into one particular religious world in order that we may better understand many others. Roman Catholics, Jews, Buddhists, and secularists should better understand themselves and others by virtue of their acquaintance with the experience of this single congregation. They will have to suspend their disbelief momentarily and try on a different way of thinking and acting, but by empathically watching how people relate their particular beliefs and values to their experiences with illness and suffering, they can actually see a faith tradition at work.

Furthermore, this short expedition into one world of belief should illuminate more general features of the relationship between traditions of belief and the modern situation. We can watch the ways in which people edit, re-explore, and refashion the heritages that first shaped them.

What did we learn over the course of the discussion group meetings? The articles that follow allow several of the participants to answer for themselves. But before turning to them, it may be useful to highlight several observations that recurred in the group meetings and in the accounts of personal experience. These should not be viewed as definitive points but as opening remarks designed to stimulate thinking, raise new questions, and provoke alternative explanations.

1. *What is true of religion and society in general is often especially true of views of faith and health in particular congregations.* Scholars from a variety of disciplines have converged upon one word to describe the basic religious reality of our age—*pluralism*. They catalog denominational varieties, they do statistical profiles of beliefs within individual denominations, they poll the nation on everything from stances on abortion to gun control legislation, and they find that the evidence of pluralism only increases. Perhaps it was once possible to find intact subgroups in which people could be counted on to think and act alike. But with the exception of groups that make conscious decisions to demodernize and enforce uniformity upon their members, the trend toward

The last thing we moderns want to do is let our failures, flaws, illness, and need come into view.

diversity of opinion is burgeoning. In such a pluralistic environment conventional shorthand labels do not seem to tell people very much anymore. Identifying oneself or another as Democrat or Republican, Lutheran or Catholic, physician or teacher, liberal or conservative does not disclose so very much. Particularly in matters of personal health, faith, and ethics, such labels do not prove to have especially apt predictive power. Will a person so identified have an abortion, choose to withdraw food and water from a dying grandparent, or seek a liver transplant for a critically ill child? One might be able to make a reasonable guess if one knew the decider to be a Lutheran shopowner in suburban Chicago with a long Republican voting record, but it is also quite likely that at certain decision points the individual would not fit the mold. People tend to make selective use of a variety of perspectives, as sociologist Peter Berger has reminded us. Using the exotic-sounding French term *bricolage*, Berger calls attention to the fact that moderns do not approach reality with one enduring model of their world or themselves (Berger, Berger, and Kellner 1974:109). Instead, like children with a collection of Tinkertoy parts, we tend to put together, take apart, revise, and fiddle with a variety of oddly shaped components until we find a shape that seems right for the moment. The next day, the process may very well begin again.

Berger's image can be useful to those probing for relationships between a specific faith tradition and personal experience. Although the size of an individual

Tinkertoy set may vary, the variety of sources for opinions and beliefs that impinge upon the twentieth-century U.S. citizen makes it likely that before too long pieces of different colors and sizes from other construction sets will somehow have slipped into the person's original kit.

People bearing faith traditions have a rough road to travel in such a world. Or to mix metaphors further, with so many competing religious and secular traditions clamoring for attention, it is hard to keep one's ear tuned to just one channel. That difficulty is compounded by the pluralism of interpretations available within most major faith traditions. As members of Grace Church learned all too well, people frequently make passionate and contradictory appeals to a tradition in order to advance a particular cause or moral stance. The combination of pluralism *of* traditions and pluralism *within* them results in fragmented relations between congregations, members, and their cherished heritages. At Grace Church, for instance, the word *Lutheran* has carried several meanings. Furthermore, members relate to their differing conceptions of Lutheranism with varying degrees of commitment. Faced with a version of the tension between tradition and modernity that arises in any religious group more than a few days old, the congregation finds itself, like it or not, estranged from its tradition even when it seeks to invoke it.

Thus a pastor or member may believe that a specific element in Martin Luther's seminal teaching about the

gospel is germane to a discussion about allocating health care resources in our society. But how does that person appeal to the doctrine of the two kingdoms. Luther's classic exposition of the two types of existence possible in a world populated with many who do not center their lives in Christ and the smaller number who do? Most Lutherans have at best only the vaguest idea of that doctrine, and will, should they wish to make use of the concept, be quickly inundated with interpretations of its meaning. Or how does one retrieve the theology of the cross, so central to Luther's teaching, in a culture that has so many ways of covering up suffering or robbing it of its meaning? Luther could call suffering "the colors of the court" and mean by that phrase that suffering was a vital part of Christian identity and self-understanding.¹ Contemporary Lutherans have been so saturated by alternative understandings that Luther's version can sound foreign, and to some perverse. For people trying to remain in continuity with their traditions, the religious background noise that floods their consciousness makes the task difficult, and, in places where new ethical questions demand immediate response, almost impossible. The pluralistic context may be daunting to many in a congregation, but attempts to relate traditions of faith to modern experiences are destined to fail if lessons about that context are not learned.

Clarity about pluralism helps account for the discovery in each of Grace's working groups that self-consciously Lutheran people often drew upon sources

outside of their tradition for the fundamental metaphors and principles by which they interpreted their experience. Two nurses in the health care professionals group made use of stoicism and positive thinking to help themselves and their patients deal with suffering. One member of the chronic illness group relied upon the enlightenment of modern medicine for healing while another rejected medical interventions and followed the road of charismatic faith healing. A recurring problem for the group of grievors was the American assumption that grief could be mastered in a week or two and that life then returned to normal. Encounter with such assumptions forced the groups to reexamine their traditions and test the adequacy of their theological constructions of reality.

2. *One feature of modern life, the phenomenon of privatization, poses particular problems for congregations.* The unlisted telephone number, the high-rise apartment building, and the No Solicitors and No Trespassing signs on doors and driveways bear witness to a boundary line that moderns draw between public life and their private spheres. Homes have become castles, and too often fortresses, where people retreat to cultivate aspects of personhood that seem to be out of bounds in the world of office, classroom, hospital. In their private worlds people collect stamps, do cross-stitch, view adult-only videotapes, plot their horoscopes, cultivate orchids, or read Dickens. What seems to matter most is not so much what one does with a particular private space as that one has it.

Despite attempts throughout most denominations to retrieve a sense of the ministry of the whole people of God, the tendency to think of ministry as the job of the paid clergy prevails.

One of the most perplexing problems for people who want to live out of faith traditions is the modern conditioned reflex that automatically turns religious beliefs, ethical questions, and health-related realities into private matters. What is more, congregations have been understood and often understand themselves as zones of privacy, where religion is kept at a safe distance from the “real world” of politics, economics, and the dominant social structures. When a congregation sets out to examine the relationship between personal illness and faith in such a climate of opinion it faces an almost insurmountable obstacle. People don’t expect congregations to be places where public policy about health care is debated, where moral discourse about the great health-related issues of our age is conducted. Furthermore, questions about personal illness or personal belief seem intrusive, an invasion of privacy even within this so-called private sphere.

Entitlement to privacy is a precious pillar of the Enlightenment heritage which played such a large role in the creation of the United States. Thus to attempt to step across the boundary can seem uncivil, even un-American. In *Habits of the Heart* sociologist Robert Bellah and a group of his colleagues examined assumptions about individualism in American life and concluded that this element in the American genius is also a large part of the American burden (Bellah et al. 1985). Our nation, which has placed such a premium upon the freedom of each individual to think, say, and do what he or she feels is best, has made it extremely difficult

for authentic communities to form and continue. The cultivation of the private sphere and the exaltation of individualism have rendered traditional patterns of community life dysfunctional.

Such modern habits of thought collide head-on with aspects of our much older faith traditions. Lutherans, for example, find Martin Luther, often celebrated as a great defender of the individual conscience, clearly advocating conversation among congregation members and mutual consolation as primary means for communicating God’s forgiveness to Christians. The conversation he referred to was not idle chit-chat between worship services over coffee. It was to be strenuous searching for sin and proclamation of the gospel between people who saw one another as saint-sinners. How far Lutherans are from that communal sense can be glimpsed in the writings of this century’s most influential Lutheran. In the dark Hitler-stained years when he was leading an underground seminary in Germany, Dietrich Bonhoeffer tried to call his students back to Luther’s understanding of congregational life. In his little classic, *Life Together* (1954), the martyr-theologian made the claim that the “break-through to community” came only in confession. By *confession* Bonhoeffer did not mean either private conversation with God or liturgical expression in corporate ritual. Both had their place in Christian life, but something else had to occur if true community was to exist. For Bonhoeffer, confession meant the “public death of the sinner,” a notion that can scare away even the most

well-rooted Lutheran. For those informed more by civil forms of religion or for those who seek to keep their religion invisible, Bonhoeffer's call to publicness can sound only terrifying or absurd. The last thing we moderns want to do is let our failures, flaws, illness, and need come into view.

But lest we miss what is at stake in this discussion of privatization vs. publicness it is important to press on a little further with Bonhoeffer. Why was confession so important for him? It wasn't merely that he was interested in an honest community, although he clearly placed a premium upon honesty and integrity. Much more was at stake.

We cannot find the Cross of Jesus if we shrink from going to the place where it is to be found, namely, the public death of the sinner. And we refuse to bear the Cross when we are ashamed to take upon ourselves the shameful death of the sinner in confession. In confession we break through to the true fellowship of the Cross of Jesus Christ, in confession we affirm and accept our cross. In the deep mental and physical pain of humiliation before a brother— which means, before God—we experience the Cross of Jesus as our rescue and salvation.

To late-twentieth-century ears Bonhoeffer's use of "brother" sounds sexist, noninclusive. Yet he meant the word to carry exactly the opposite meaning. By standing before another flesh-and-blood confessor, who shared

the same paradoxical saint-sinner character of the one confessing, a Christian could step into the presence of a forgiving God. Not to take the step is to risk missing that encounter with forgiveness, to confuse cultural religion with grace. Thus, the "brother" (and sister) becomes the key.

Who can give us the certainty that, in the confession and the forgiveness of our sins, we are not dealing with ourselves but with the living God? God gives us this certainty through our brother. Our brother breaks the circle of self-deception. A man who confesses his sins in the presence of a brother knows that he is no longer alone with himself; he experiences the presence of God in the reality of the other person. (1954:114–16)

The tension that such assertions raise in modern readers indicates powerfully how deep the rift between public and private life can be. At Grace Church, the reflection groups repeatedly came to the edge of that divide. The stories that follow are signs that decisions were made—at each meeting, in each conversation—to open a wedge into private spheres so that the confessional moments Bonhoeffer called for could occur. And they did. In the health professionals group one nurse set a pattern for the others when she volunteered a portion of experience that she had kept private for more than a quarter century. Ordered to inject an unusually large amount of a painkiller into a patient in the last stages of a brutal battle with cancer, she had known her

All too often congregations seem to be fenced off from the very realities that called their tradition into being.

own dark night of the soul. Should she obey the physician's order and become a part in what might be illegal euthanasia, or should she challenge the doctor and jeopardize her livelihood? Or should she withdraw from the case, leaving a patient who had come to trust and depend upon her alone as death approached? She revealed her choice: a decision to question the doctor, followed by another to administer the medication. Other professionals in the group soon followed her lead with their own private burdens: medical mistakes, assistance to someone who sought an abortion, decisions to terminate treatment. They concluded that there was no place in their professional worlds for them to address their deep personal moral and ethical quandaries. Nor was there a place for them to receive the forgiveness they occasionally sought. They also told the congregation an important message: in all the worship services, educational opportunities, and social activities of the congregation, they had never found a place where they could experience what Luther and Bonhoeffer had envisioned for congregational life. This surprising encounter with mutuality had been a first experience, and that it had happened among professionals who normally did not share such parts of their experience with even their closest colleagues had made it all the more precious. The griever and those suffering from chronic illness had similar moments when doubts, frustrations, fears, and failures for the first time met with the public death and forgiveness of confession.

3. *Congregations have special roles to play in the human enterprise of healing.* At regular intervals members of the groups mentioned particular elements in congregational life that had been meaningful, even if the direct personal encounter between faith tradition and personal experience had remained undeveloped. Participation in the choir, sermons, Eucharist, membership in the congregation's religion and literature group, or a specific moment of pastoral care were cited as ways in which the congregation was already providing important ministry to its members. Such reminders gave opportunity for the congregation to become more aware of what practical theologian Don S. Browning (1988) has called the "ecology of care" within a congregation. The Lutheran tradition boasts an understanding of ministry based on a "priesthood of all believers," but this has until the last two decades been almost entirely overwhelmed by modern models of professionalism. Despite attempts throughout most denominations to retrieve a sense of the ministry of the whole people of God, the tendency to think of ministry as the job of the paid clergy prevails. Looking at the actual patterns of care within the congregation revealed more explicit connections between the church's tradition of ministry and the countless efforts to care made by Grace's members. Blind spots in Grace's congregational ethos could also be identified.

Even more important than increasing sensitivity to the actual ways care is and is not provided to its members and its community was the reperception of the

congregation's vocation. During the past century the synagogues and churches of the land seem to have gone along with dominant social trends that confined healing to the work of medical, psychiatric, and social work professionals. Congregations and clergy seemed to acquiesce in the separation of healing and congregational life. Occasionally pastors or rare congregation members made visits or sponsored specialized healing ministries under denominational auspices. But even when making redemptive forays into the health care arena they tended to regard healing as the responsibility of health care providers.

Grace's two years of exploration into the relationships between health and faith made it clear that although the health care industry has many wonderful gifts to offer suffering people, many parts of human life remain untouched—unhealed—even after the surgeon or the counselor has completed work. Indeed, griever, the chronically ill, and health care professionals alike provided ample evidence that modern health care is at its best an ambiguous creation. It wounds while it heals; it solves one set of problems only to create new ones or exacerbate old ones. The deep human needs for healing can exhaust the resources of even the most technologically advanced, well-financed health care system.

Part of re-perceiving the congregation's role involves debating the meaning of healing. The nation's popular media bombard citizens with images of the good life, of health. The perversity of some of those images—the perfectly fit, well-tanned tennis player smoking the

cigarette, the almost anorexic model wearing the latest fashions, the successful executive sipping scotch straight—has only recently become a concern for our society. In addition some medical assumptions about health reduce well-being to a state of being disease free or optimally functional. To ask about healing for the divorced or widowed person, the terminally ill individual, or the burnt-out nurse is to push for a larger, more inclusive definition, opening the healing enterprise to beliefs, meanings, and realms of the human beyond the biological. In this zone of life, in which we deal both with ultimate questions about life's meaning and with the everyday events where fracture of relationships and self-worth occur, congregations seem strategically situated to act—and to heal. To do so will require, as Grace Church has discovered, that congregations understand healing as central to their reason for being. They will need to ransack their own traditions for images of well-being and resources for healing; they will need to touch the dimensions of modern life that get pushed into the private sphere.

Once the process of re-perceiving gets under way, the naturalness of claiming a healing role for a congregation becomes obvious. Congregations bear traditions that seek to address the deepest of the deep realities of human life. These traditions attempt to address, if not always explain, the great problems of suffering, evil, death, and brokenness which humans experience. Grace Church's tradition majors in questions about sin, death, suffering, and evil. The Lutheran genius can be

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found in the encounter with these problems and the solutions it offers for them. But religious traditions also seek to celebrate the dimensions and wonders of life, birth, relationship, community, and joy. Nearly all of the great traditions have given significant attention to healing, to restoring humans to wholeness, peace, and meaning.

A troubling aspect of modern religious life is that all too often congregations seem to be fenced off from the very realities that called their tradition into being. In 1961 Gibson Winter, professor of ethics and society, warned about the “suburban captivity of the churches,” his phrase for the restriction of much congregational life to social activities, entertainment, and an unthinking endorsement of the American way of life. More recently theologian Langdon Gilkey (1981:7) has asked if the entire Western culture, which traces its ancestry back to the Enlightenment, the classic Western religions, and the Greek philosophical traditions is confined in a global suburban captivity that renders all of the West’s traditions impotent and banal. Diagnoses like Winter’s and Gilkey’s may overlook exceptions and bright spots on our culture’s religious horizon. But they serve the important purpose of setting individual situations and problems into larger patterns and contexts.

Pluralism, privatization, and the separation of healing from faith are signs of the culture-wide perceptual shackling that tends to isolate a given faith from the important areas of life and from encounter with the problems that gave rise to its distinctive witness. Thus

reperception becomes essential not merely for individual or even congregational health. On the contrary, reperception becomes essential for the health of a given tradition, allowing it first to return to its deep problems and solutions, next to reassess its relationships to its current contexts, and finally to take a step into the midst of the lives of its most recent adherents. When a congregation chooses to relate human health experiences to its faith tradition, it thus has opportunity not only to help its members but to enhance its larger tradition.

For such reperception to become something greater than one more private opinion it is essential that each congregation become what theological ethicist James Gustafson once termed a “community of moral discourse” (1970:83–95). Matters of right and wrong, good and evil, better and worse need to be retrieved from the private spheres of members and brought into a forum where the tradition can have a full-blown encounter with modernity. The alternative is to let piecemeal and partial ethics pass themselves off as surrogates for the ethics of a faith tradition. How can an individual rise above the tyranny of his or her private opinion if no place exists where proposed courses of action can be debated and evaluated? The testimony of the Grace Church members was that no such forum existed in their work, home, or religious worlds—especially if religious beliefs were to be part of the discussion.

In order for a congregation to become a community of moral discourse it must be many other things first.

It must be a community with common memories and experiences, a community with a common language and a common referent. All of these elements are supplied by a congregation's great and small traditions. But beyond the frameworks provided by traditions there must be a specific openness to moral questioning. Many of Grace Church's members assumed that their congregation was the last place where questions about abortion, divorce, and euthanasia could be raised, especially if those questions were to be treated in anything other than an abstract way. They hesitated to let their moral uncertainty show among people who all seemed so healthy, so upright. The obstacle they met—and for the most part retreated from—was the image of perfection that the congregation had worked for more than eighty years to maintain. How could personal failures and flaws be acceptable in a place where the choir was always in tune, the sermons always well delivered, the people always well-dressed, the budget always balanced? It was only when a place was created that allowed people to express their vulnerabilities and shed their upper-middle-class veneers that true moral discourse could occur.

In addition to providing people with other perspectives, new knowledge, or a sounding board, the moral conversations these groups shared made possible occasional rapprochements between people and their heritages. By creating a *community* of moral discourse, these individuals developed the possibility of sustained and deepening ethical reflection on decisions that

previously had to be made in the marginal spaces of their lives. They found an acceptance in the midst of their questioning which fostered further reflection beyond the confines of the groups and a strengthened will to stay with an ethical issue until it was resolved.

This type of moral conversation raised two issues for the congregation members. On the one hand, they searched for the existence of a distinctively "Lutheran" ethic; they were forced to the marrow of a tradition that holds up "life under the cross" and the "invisible struggle between sin and grace" as paradigmatic. On the other hand, their moral discourse made them more attentive to their congregational ethos: they raised questions about healthful ways of living, about justice, about the congregation's responsibilities to its community. Those questions in turn have established a new agenda for the congregation—one that forces it back into its tradition, into the lives of its people, and out into the society that surrounds the church building. All this happened because the congregation provided a place for people to tell their most important stories and to seek connections with the master story of their tradition. Now it is time for some of those storytellers to speak for themselves. ☸

NOTE

1. Martin Luther, "Sermon on Cross and Suffering" (1530), *Luther's Works* 51:199.

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Poor People, drypoint by Edmond Blampied, 1924.

National Library of Medicine, Bethesda, Maryland

The Sufferer's Experience

A Journey through Illness

Stephen A. Schmidt

YEARS AGO A PROFESSOR in one of my seminary classes stated that "Luther theologized from experience; to use a bit of a pun, Luther can only be understood from the bottom up." There was in those words not only good humor concerning Luther's well-known bouts with constipation, but profound wisdom about a basic theological principle, that of beginning with reflection on experience.¹ I recently relearned its meaning after long neglect as I was forced to search for meaning in the same existential manner.

Part of my personal spiritual reflection had to do with vocational turmoil. Moving from a comfortable Lutheran college setting to teach at a Catholic women's college introduced a new series of theological considerations. Lifelong convictions faltered in the arena of my

new religious situation. When the fall term of 1976 began, I found myself at Mundelein College in Chicago in front of nuns, priests, and young Catholic female students—a strange place for a self-consciously Lutheran theologian. I began to teach Catholic theology and felt completely disoriented. Those first weeks were filled with compassion and love from my new colleagues, the gentle Sisters of the Blessed Virgin Mary (B.V.M.'s), and patient students. They were also filled with absolute terror. I didn't know enough about Catholic theology. What was I, a male Lutheran, doing among all these female Catholics? Should I participate in Eucharist? Dared I deliver a homily? Would I ever really enjoy soft, feminine, folksy liturgical music with guitars after a lifetime of Germanic (masculine) militant organ and

Arising from personal arrogance and pain, the “why” question is the symptom of being most human, of being absolutely like every other human self.

chorale music? I was confronted with this new situation as a result of turmoil in my “home” denomination, turmoil that cost me my job and eventually my health.

Sigmund Freud once wrote that the essence of meaningful life was good love and good work. The latter half of that equation had been severely disrupted by my vocational crisis in the 1970s. And now love, the other part of the equation, also seemed threatened. Marriage was routine. The continuing responsibility of fatherhood, the dullness of twenty years of habit in an all too symbiotic family system seemed desertlike and non-nurturing. My wife, “Gick” (Hildegarde), became strangely more assertive. She was transformed by early feminist ideals, and although I could give intellectual assent, my sentiments still beat to older, patriarchal rhythms. Our struggles grew intense, each of us feeling trapped in a vow made years earlier to someone hardly recognizable in our present spouse. Fidelity faltered; promises small and large seemed in jeopardy. The whole family felt the chronic discord.

We sought help in family therapy, and we started to struggle with aspects of our discomfort that could be traced to our families of origin. I began a serious attempt to reconcile childhood misunderstandings and pain, first with my father and later with my mother. She and I were making an honest effort to understand the genesis of my struggle.

In the midst of these months of painful conversation, letters, and visits, my mother died suddenly of a stroke. We had known of her hypertension; indeed,

I had always been cautious with some fear that my choices might bring on these very consequences. In retrospect, I felt only slight tremors of guilt. Instead, I felt almost angry that she chose to end our conversation so abruptly, as though she had had the final word and now dramatically refused to listen. I told her these things as she lay in a coma. Our last conversation, my talking and her not responding, ended just two hours before she died. The only movement I knew was a hand squeeze when I told her of my love, even as I struggled with anger, regret, and memories of sadness. A mother’s death is never easy, and my grief was direct, open, and healing. But residual pain rested in my inward parts, in my central person.

The first pains were brief, like those I remembered from adolescence. They came at odd times, lasted only hours, and passed, perhaps caused by something I had eaten, I thought, or perhaps related to stress. After my mother’s death, they seemed to recur more often, until one night they returned and remained. The pain was in the abdomen, to the right side. It woke me from sleep, and within the space of two hours I knew something was seriously wrong. My stomach was distended, the spasms recurrent and intense. We rushed to the hospital emergency ward and there awaited a diagnosis. Although uncertain of the origin of pain, the doctors knew that there was a complete bowel obstruction and that surgery was indicated. My wife called our four children at their respective colleges, and by 7:00 A.M. they were at my bedside, their faces filled with affection and concern.

The surgery was successful. The diagnosis was Crohn's disease, an incurable, chronic inflammation of a segment of the digestive tract. The prognosis was relatively positive: Crohn's doesn't kill; it just makes life miserable. By careful medication and cautious monitoring of one's diet, one could expect to lead an active, productive life. Stress seemed to intensify the symptoms. Because medical professionals don't know what causes the disease, they cannot cure it. So one lives with chronic discomfort and learns that life often has a retributive quality. Eat carefully, drink moderately, don't get angry, stay mellow, don't become depressed or too excited. By following this simple program I could live life fairly symptom-free.

My recovery was rapid, and I resumed my duties as director of the graduate program of religious studies at Mundelein. I began again to feel energy, and I thought that the days and months ahead would be bright. Nonetheless I felt chastened by the experience. My mother's death and my own bodily vulnerability taught me to face life a bit more tentatively than before. I modified my activities, tried to live more carefully, and felt for some weeks that I was learning from my experience.

I was, however, not ready for the next tragedy in my life, one that altered my psyche more than any experience before or since. It happened October 18, 1978, about two months after my surgery. My wife had gone to visit friends of ours just blocks away, and I was waiting for Ruth (sixteen), our youngest child, to return from work at the Altenheim, a nearby residence for

senior citizens. She probably stayed after work to talk, I thought. But as the time passed and darkness began to merge with the sunset, I became strangely uneasy. Finally, at about 9:00 I heard her run up the porch stairs, banging the door, crying "Dad, Dad." I rushed to open the door and knew before she screamed the words that she had been cruelly raped. Her face was ghostlike; tears flowed as she clung to me, enfolded in my arms, and poured out her story. "I've been raped, he kept me and threatened to kill me, finally he let me go, I've run all the way home."

The next hours are vividly etched in my memory: the phone call to Gick, who rushed home in tears and terror, the hospital, the detectives, the profile sketched by Ruth for the morning paper, the visit to the place of the rape, a lost comb and a handkerchief.

In the days and weeks that followed, the pain was softened by friends, family, and hope. Eleven years later, Ruth's recovery and renewal are still incomplete, but she has been transformed. That night transformed family and father as well. The pains returned; the hurt turned in and registered again in my gut. Slowly, ever so slowly, life went on; we sought to return to reality, to hope, and ultimately to routine. But some things don't heal; some parts of hurt and evil remain embedded in our heads and our bodies forever.

Such were the circumstances that brought me to the beginning of a very needy period in my life. The Crohn's inflammation recurs regularly, almost cyclically, in the fall with the beginning of the academic year, during

There is somewhere in our conventional wisdom the notion that “tragedy brings families together.” That was not our experience.

October with the anniversary of my mother’s death and daughter’s rape, at times of disappointment or ecstasy. In the summer of 1985 a second surgery was necessary, and once again, I confronted the limitations of my being. The “thorn in the flesh” doesn’t go away.

Personal Sources for Hope and Healing

Where does one turn in such circumstances for help and solace? Where does one find the answer to the routine question “Why?” Granted, that is not a very faithful or courageous question. Arising from personal arrogance and pain, the “why” question is the symptom of being most human, of being absolutely like every other human self. Still, we know intuitively that few people enjoy listening to the regular, plaintive cry “Why?” or “Why me?”

When one is in dire straits, one turns to those closest: spouse, children, parents, siblings. Especially today, the family bears the brunt of the pain of existential anxiety; there is somewhere in our conventional wisdom the notion that “tragedy brings families together.” That was not our experience, nor has it been the experience of countless friends and acquaintances to whom I’ve spoken. Tragedy always puts stress on families, placing the entire family system in jeopardy. My wife gave the responses of her family of origin; she offered firmness, gentleness, but never the kind of re-

sponse I sought or was used to from my family of origin. Unexpectedly, as years of asking “Why?” unfolded, I learned the strong value of my wife’s responses. Because she knew me so well, she refused to affirm my whimperings, almost ignoring them. So my neurotic efforts gained me little attention, while my sometimes rational understanding of my illness was affirmed and received.

My children were less able to help routinely. They cared a great deal and openly expressed that care. But their lives are rich and just emerging; in their twenties, they are struggling with their own questions. One learns that fatherhood doesn’t cease even when one feels like being a child.

A second source of support came from our family therapists. Since we had established a relationship with them before the advent of the disease, the rape, and the death, they were like old friends or family doctors, available as we needed them. At times one or another of us has returned for short-term help. Their professional training did not equip them to deal with the reality of death, but they also had no pretensions about doing so. They left religious questions to other disciplines, encouraging us to use the resources of our own faith.

I turned as well to the medical profession for support and encouragement. Because my surgeon was a caring person and deeply Christian, I experienced continual support. I came to understand that medicine is less helpful in matters of nutrition and holistic considerations than in radical procedures like surgery and

drug therapy. I learned slowly that my body was its own best physician. I learned as well that medical practice is practice, that doctors work with uncertainty, sometimes with blind faith, and always with their own experience of ambiguity. Fortunately, my doctors perceived the limitations of their promises, and I came to see the possibilities of a very important partnership: medical healing is at its best when patient and doctor join their resources for wholeness and healing.²

One also turns to friends and colleagues for mutual support and encouragement. Throughout my adult life, I have needed and experienced the personal satisfaction of having a close group of male friends. Because my job shift removed me from my primary friendship circle, I have learned the meaning of continued friendship maintained within the limits of occasional visits, phone calls, and letters.

Religious Sources for Healing

Religion can be a wellspring of faith and hope. Although one's family, friends, and colleagues are all in one way or another part of one's religious community, for me, the sources of healing also lie beyond human relationships, even the most intimate. Religious traditions bring ideas, symbols, values, and myths to one's armor of hope. Indeed, one could argue that the entire theological enterprise is always a questioning dialogue between experience and the storehouse of stories from one's religious traditions (see Tracy 1975: 34, 49ff.; 1981:

98–229). My own tradition is Lutheran, so naturally its insights were the ones I found myself applying to my situation.

The founder of Lutheranism was a man who dwelt much upon the painful realities of life. He reflected deeply on his personal existential situation as well as on his concern about the larger experience of the Catholic church. The disease of sin, the “wrath of God” that Martin Luther wrestled with, were closely related to the experience of God in his life and in the church. If, then, one's disease is painful, causes conflict, and forces one to look with dreadful seriousness at life, Luther is an excellent companion for the journey.

Luther's theological perspective was earthly, sometimes even vulgar, and his theology of creation is a good place to begin if one seeks earthly comfort for earthly physical disorders. For Luther, creation was an ongoing order reflecting God's creative activity. Luther's explanation of the first article of the Apostles' Creed for children (in the Small Catechism) clearly cast God as motherly nurturer. God “sustains my body and soul”; God “preserves me from all evil” and does all this out of “divine goodness and mercy.” So if one wants to understand creation, one looks to the existential present: “God has created me and all that exists.” And the natural response, according to Luther, is to accept such providential care “without any merit or worthiness.” If one can receive life so graciously, then surely one is bound to “thank, praise, serve, and obey” God for all these good gifts. Health is such a gift, never a natural right of life.³

How do a benign creation and merciful God give birth to disease and illness? How does creation reveal God's care when our experience is of the opposite reality?

What, then, is the experience of illness? How do a benign creation and merciful God give birth to disease and illness? How does creation reveal God's care when our experience is of the opposite reality? Luther writes with disarming clarity:

For whenever they behold a work of God, they imagine how conditions would be without it. Death ennobles life, darkness praises the sun, hunger kisses the precious bread, sickness teaches the meaning of health, etc. The word "not" prompts them to praise the "being" [*Wesen*], and this implies that they search, explore, and ponder the works of the Lord, esteem them, and imagine what the world would be like if these works had not been created. Then they rejoice over them and behold them as real miracles. (Quoted in Marty 1983:29)

In characteristic fashion, Luther suggests that one can learn meaning in meaninglessness.

A second element of Lutheran thought is the oppositional dialectic of a theology of glory with a theology of the cross. Luther lived and learned amid the Roman Catholic church's celebration of its ecclesial success, its beautiful cathedrals, pomp and circumstance, liturgy and lace, richness and power; God's presence was comprehended in ritual and ceremony, in the artifacts of icons and the idolatry of relics. This theology of glory turned confession and absolution into penance, slightly ways of caring for the unsightly reality of sin. A

theology of glory relegated power to priestly office and turned shepherds (bishops) into wealthy landowners. Such a church, Luther believed, was captive to a diabolical misunderstanding of God's way with God's children.⁴

A theology of glory continues to plague the modern church—and not just the Roman Catholic expression. Success measured by increased membership or new building programs is symptomatic of glory theology. In personal terms glory theology seeks to guarantee perfect bodies and attempts to deny death and its signs. A theology of glory prays incessantly for health, demanding God's intervention but naming as well the result—renewed wholeness. A theology of glory turns pastoral care into therapy, prayer into magic, and healing into scientific perfectibility.

Luther's response to a theology of glory was the theology of the cross, the reinterpretation of life lived in the shadow of the cross. At the cross the immutable, all-powerful God became a God of weakness, a God who suffered. Christians are people who live out all experience in that shadow, hence perhaps the grayness of some of Luther's language. The theology of the cross was not a neurotic misapprehension of life or some narcissistic, sick way of seeing reality. Death continuously stalks life, and surely its presence in the sixteenth century was less masked than in the twentieth.

Why would Luther, or anyone for that matter, adopt such a perspective? There are happier perspectives on life, but not, according to Luther, for the Christian. The

beginning of the Christian experience of the cross occurs in baptism with “the sign of the cross on the forehead and the breast.” God calls a Christian in baptism to real death and real resurrection, symbolized by the cold immersion and stark nakedness of the body plunged into the water. As a modern Lutheran, Dietrich Bonhoeffer, wrote: “When God calls a Christian he calls him to come and die” ([1949] 1960:79).

But we misunderstand Luther’s faith if we end our discussion of his theology of the cross with its deathly reality. For Luther, the crucifixion was always united with the experience of Easter. Human suffering (from a Christian baptismal perspective) is a partnership with the redemptive suffering of God. Bonhoeffer (1985:56) wrote that

in Jesus’ healings the cross is prefigured. Healing shows that Jesus receives and bears the sick in their weakness, *a weakness he will bear on the cross*. Only as the crucified One is he the healer. Among the sick we learn more about the world and come closer to the pangs of Jesus’ cross than we do among the well.

Thus sufferers win an existential victory because they participate in a suffering already completed and judged redemptive, acted out in Jesus’ resurrection. As the highest end goal of life for Christians is a blessed death (indeed for early Christians, martyrdom), so Christian sufferers suffer with hope, not as those seeking perfect

bodies but as persons who hope against hope that Easter will happen in their final death as well as in their symptom-filled lives. Suffering, diseased persons know the experience of the cross, even if they have never heard of Luther.

Suffering is part of the humbling experience of having to rethink one’s natural tendency to ignore death. Suffering serves a purpose: by obliterating the personal temptation to assume that one is somehow in control, it exposes one’s desire to be like God. Luther’s view of life would also keep us from insisting that health is the whole or main aim of Christian experience, that salvation must be experienced in full in this life. Luther understood that God accepts sick persons as well as those who are healthy. For those with a similar vision, this means that despite modern medical advances, health remains a gift of grace, not the common expectation of all humankind. Most humans die sick, most with very little dignity, and some with terror and struggle. Luther’s theology of the cross expresses all the vulnerability and terror that most human beings really experience at death; it echoes the question “Why have you forsaken me?”

Luther’s view of faith had most to do with trust: “God is that to which your heart clings.”⁵ Faith means trusting God’s promise in impossible situations. The seemingly unnatural aspect of faith leads one to “groan with inexpressible groanings”; one allows “the spirit to pray” when one cannot formulate words with one’s own voice. Applied to chronic illness, such an under-

Luther's theology of the cross expresses all the vulnerability and terror that most human beings really experience at death; it echoes the question "Why have you forsaken me?"

standing of faith can be modestly helpful, as the Christian suffers with "hope against hope." Such hope is offered in the face of terminal cancer, AIDS, Crohn's, or hepatitis.

All the while such faith remains terribly fragile, as it clings to hope without a shred of evidence. It stares at death and accepts its mystery, only seldom achieving in this life a glimpse of hope about the next life. But chronic illness sometimes leads to spiritual maturity and may even lead one to be able to speak and experience these words of Luther as one's own:

We die not only mentally and spiritually by renouncing sins and vanities of this world, but in very truth we begin to leave this bodily life to lay hold on the life to come, so there is, as they say, a 'real' and bodily passing out of this world into the Father.⁶

If faith is trusting God's promises in impossible situations, where then is the objective reality that God is to be trusted? For Luther, the resolution of this question lay in his understanding of the Word of God, incarnate in the person of Jesus and remembered in the testimony of Scripture. For Luther, understanding Scripture involved a proper division of hearing the word of judgment (law) and the word of promise (gospel). Scripture was not about history or science, nor even about moral precepts or theological wisdom. When one confronted the Word of God in the words of Scripture, one always

stood in the awesome, terrible presence of God's justice and mercy.

The terrible words of God, the "wrath" of God, really served a single theological purpose—to accuse the listener. Here was a far different understanding from that of medieval Catholicism, or, for that matter, of reformed evangelicalism. God's word is never to be understood as prescription for living, as some kind of behavioral modification program, nor as stepping stones to a natural theology that would allow one, by living correctly, to bridge the chasm between the holy and the profane. Rather, for Luther, God's prophetic word brought death; it led to helplessness and despair or to pride, both "bad faith" responses.⁷

The second word of God was that of the gospel, whose light shines most brightly when the darkness of human alienation is deepest. The good news of Jesus is a word of love, forgiveness, life in death, victory in defeat, and hope. It is the final word of God, the word of Easter, that gives hope in hopelessness. The expressions of that Word were clearly located for Luther; Christ, the Word of God, was in Word and Sacrament, as they are embodied and mediated in the Church.⁸ At times Lutherans have misunderstood the Word of God, elevating the preached word over the sacramental word. Sometimes their attention to right doctrine, their preoccupation with exactness, and their inattention to the lived word, the communal word, have led to suffering. Sometimes they have overemphasized the literal words. But when they have understood word as Luther did,

it has transformed lives and healed souls and bodies. Confession and absolution (what Luther called the third sacrament) is a process of word cure.

Lutherans' attention to getting the words correct has great merit in pastoral care and the practice of healing. When a surgeon explains a diagnosis and describes the curative procedure, we pay careful attention, and the words are taken seriously. So, too, when a physician of the soul speaks words of judgment and hope, we listen with hope. The proof of the words' power is the authority and potential behind the words. If our doctor promises radical surgery as a cure, we trust her and have the surgery. The words become true after the operation. This is true also with the words of God; their authority is validated after we have lived out their impact, after repentance, faith, and prayer, after believing. Here, I believe, is the crux of the connection between the genius of Lutheran theology and the care of the suffering. If the words are true, and if they carefully reflect the Word, then the word becomes event in the life of the sufferer. It happens when the bearer of the word shares its impact, thus expressing the sacramental and communal nature of God's people.

Lutheranism casts faith in hard metaphors. Hope against hope is exactly what I have experienced since the onset of my illness. Luther's emphasis upon the imperfection of Christian experience ("sin boldly but let God's grace abound") matches my experience.⁹ The promise of perfection in any form is a false gospel and mischievous fantasy, for a quality of brokenness remains

to those who are chronically ill. This reality corresponds to Luther's notion of a fallen creation. We groan with the creaks of the cosmos and come to see God's weakness and suffering as part of the theology of the cross. God's companionship in suffering is comfort because it is both theologically accurate and experientially true.

Sometimes suffering serves as the salutary effect of God's judgment. I am not suggesting that disease or long-term illness is somehow punishment for sinfulness. Rather, illness just seems to disallow much false pride: one is not allowed much self-deception (exactly what Luther understands God's judgment to do for us), which leaves us open to dependency upon God.

Illness is also good preparation for the goal and end of life, death. It can even nurture what a colleague of mine once called an "eschatological itch." Chronically ill persons relate well to Luther's cry near the end of his own life, "we are beggars all."¹⁰ One cannot suffer over a long time without developing some sense of empathy for others who share such pain.

Finally, suffering accents grace as God's incomprehensible gift, unattained and unearned. Each day becomes a metaphor for grace. The fleeting quality of good days teaches patience and affirms the prayerful duty of Christian waiting. Suffering nurtures expectancy. One prays "come, Lord Jesus" differently, with conviction, desperation, and confidence; one waits and grieves with hope for another visitation and final wholeness. There faith becomes sight, and the new reality of life fully whole is lived with God eternally.

Medical healing is at its best when patient and doctor join their resources for wholeness.

The Parish as a Healing Partnership

These insights are never learned from books alone. One does not study Luther or read his volumes of theology and feel suddenly healed. Such an experience would be rare indeed. Rather, these insights are discovered in the lived reality of the Christian community, and that experiential space is for most Christians the place of the local parish or congregation.

When beset by chronic illness, if one is Christian, one turns naturally to one's faith community, one's church congregation. In my own case, the initial call for help from that community was made by my wife, when, on that very scary Sunday morning in 1979, she called the parish office to ask the community to pray in my behalf. The pastor, as the representative of my worshiping community, assured her that such prayers would indeed be offered, and then he rushed to the hospital to join my family and me in a fervent prayer before my emergency surgery. None of us knew the extent of the illness or its source. I gave over my body to the hands of the surgeon I had met only hours before and prayed with fear and trembling that his hands would be skilled.

I did not know, as I groggily entered the operating room, that in the next five hours, while a team of doctors and nurses performed the surgery, a new and recent friend, a fellow parishioner and choir member, Dr. Herbert Greenlee, director of surgery at nearby Hines Veterans Hospital and associate director of surgery at

the hospital where I found myself, came to the operating room without any request from my family to be present for most of the surgery. It was he who first informed my family of the apparent success of the procedure and assured them that all would be well. During the next two weeks, he regularly dropped by on his rounds to check on my progress and give encouragement and just plain friendship. No bill ever arrived. His ministry in my healing was simply that of a fellow Christian showing care and concern for another of *Gottesvolk*, God's people.

During these two weeks, other members of the parish, including two who were nurses, dropped by regularly. The pastors came regularly, even when uninvited, and sometimes I felt genuine, though minor, resentment: I didn't need professional prayers. Because I was a long-time member of this extended Lutheran community, other professional ministers dropped by, more than I could count and much to my dismay. I always felt they knew something of my personal anticlericalism, and I interpreted their visits somehow as retribution for my public ambivalence toward professional carers. I could hardly debate matters of ministerial status or ecclesial governance with tubes in my nose and arms, a very sore throat, and a painful gut, but I usually made my disposition known. In retrospect, I see that these pastoral calls were probably offered with genuine compassion, but I believe I discovered a basic principle about care for the ill: it should be given when requested and rarely imposed.

It struck me that compassion and love can be given primarily only by those with whom one has some personal relationship. The ministry of healing is part of a relationship of meaning. When friends or invited colleagues or students visited, I felt nurtured; when an institutional representative visited without invitation, I felt that my privacy had been invaded. I found in those early weeks that the most helpful care was given by those who really loved me, who had some relational intimacy with me. In the weeks and years to come, I had much more to learn about the ultimate value of natural compassion and care, given by a real community of persons who find unity and support because of their neediness and common experience of illness. I learned something of the true nature of the consolation of the communion of saints and something of the danger of its formalization, professionalization, and institutionalism. In later years, I learned that professional carers and church members are not necessarily separate communities but are ultimately in need of the resources of each other. There can be no caring community without institutional structure, and there can be no real professional care without the intimacy of mutuality. That insight resulted directly from my parish experience at Grace Lutheran Church.

The Chronic Illness Group

The formation of a church group for people struggling with chronic illness began quite simply with a written

letter of invitation sent by our pastors. The letter was sent to those parishioners known to have some form of chronic illness. A more general invitation was extended by newsletter to any other members of the congregation who struggled with long-term illness. As I recall, the letter raised several questions. Was there any relationship between faith and sickness? Did being sick affect one's faith perspective? And how could Grace Church be more supportive to such persons? I remember being curious about the invitation and wondering if there was a hidden agenda, but I was enthusiastic about having a chance to share my pain and frustration in the struggle with Crohn's disease.

Few models for forming such a group existed in any parish. There was no specific model at Grace for self-sustaining peer ministry groups. When the group first met, the format, agenda, and style of group interaction were naturally influenced by the pastors' leadership. The pastors usually formed the agenda beforehand, planning an opening Bible study and discussion, usually around a clearly defined topic. What sections of Scripture were important to us? Was there anything distinctive about our Lutheran faith that helped us in our struggle with illness? Did our illness raise questions that the parish could address or were there ways in which the congregation could be more helpful?

The first meetings also included time simply to talk about our illnesses. As we introduced ourselves, each shared his or her story, and an immediate bonding occurred. We learned something of each other that we had

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not known before. People we saw every Sunday at worship were suddenly symbolically undressed. They carried in their bodies cancer, multiple sclerosis, chronic depression, atypical trigeminal neuralgia, alcoholism, Crohn's disease, Gardner's syndrome, and other illnesses. Such revelations seemed to have a leveling effect in the group. All mutually needy, we had no title or status with which to manipulate or control the others.

Gradually, changes occurred within the group. Talking theology or ideas seemed less important than talking about our experiences. The pastors listened more and spoke less. Group members led prayers and chose Scripture readings upon which to reflect. We reached a first group decision that we would invite our spouses. More time was spent sharing new stories and by the year's end, we all seemed to agree that we needed to continue meeting. A developing comfort level emerged which paradoxically allowed for increased discomfort; our stories became increasingly honest and therefore more painful. What began with pastoral leadership slowly emerged into a more self-sustained leadership experience.

Some time in the second year, the pastors turned the leadership over to the group itself. As we met monthly throughout the next year, we focused more and more on experience. Each meeting had two parts. One member of the group would lead us in prayer, choosing some reading particularly important in his or her life. Then we would spend the next hour simply reviewing our life in the past month. I worried that this

part might become repetitious, but the stories changed dramatically each month. A dozen illnesses can create truly engaging drama. Since most chronic illness shares some cyclical symptom expression, stories changed regularly, depending on the activity or recession of the disease.

As we chronicle our diseases, we are learning from each other the parallels of our struggles as well as the diversity. Those who have had a good month, or at least more good days than bad, tend to lend support and encouragement to those whose past month was distressing. We have mutually learned the value of prayer and of praying for specific needs. We have learned, as well, the deep therapy of humor, another kind of prayer. As we grow closer, we are able to challenge each other more honestly, and we are able to laugh and tease, seeing in our tragedies the comic side of human life.

Some spouses come regularly, others occasionally, but we always struggle with the impact of our sickness upon those closest to us. It is difficult indeed to listen as one's partner in marriage shares with the group how difficult we are to live with on occasion, our mood swings, our propensity to self-pity or its opposite, arrogant self-reliance (stubbornness). But among other couples the tension is often dissipated, and we are able to discover the mutuality of our marriage struggles and feel less isolated.

Had we kept notes of our time together, we could, I think, have validated patterns of emotional responses to chronic illness. In *Beyond Rage: The Emotional Impact of*

Chronic Physical Illness, Jo Ann Le Maistre (1985) traces six stages that she observes in people coming to terms with chronic illness: crisis, isolation, anger, reconstruction, intermittent depression, and renewal. We share moments of crisis, as one of our group is told of impending radical surgery that will leave him dependent on hyperalimentation, the administration of nutrients beyond normal requirements, for the remainder of his life (he is thirty-four years old). We experience isolation as another tells of her loneliness and her need for companionship after cancer surgery and retirement. We have shared anger in our struggle with the frustration of our limits or the unfairness of our condition. Our stories about reconstructing life-styles are filled with accommodation—changes in diets, routines, jobs, and other responsibilities. Louise, an older group member, lives with atypical trigeminal neuralgia, so she has lived with constant pain in her face for years, but her reconstructed life is almost saintly. She has taught us patience and trust; complaint is not in her vocabulary. Depression is experienced acutely by some in our group and intermittently by each of us. Each reversal, the surprise of new symptoms, or the everyday pain of one's distress leads to occasional depression. But while each among us has at some point shared a story of personal melancholy, the longer we are together, the more regular are our stories of renewal. We celebrate when one is symptom free. We give thanks when one of us receives a positive prognosis, and we renew our "hope against hope" together.

Though the emotional developments characteristic in chronic illness are surely present in each participant, the sequence of emotions is not so regular or sequential. Rather, I see those developments as reversible, with changes in direction occasioned by repeated failures or renewal. What makes our time so engaging is the discovery that our lives are so rich even if physical health is lacking. My hunch is that the pattern of emotional development evidenced in our group is more one of death and resurrection, with incidences of both occurring over time. Le Maistre confirms many of the insights that we have discovered in our reflections together as a group.

Recently, in preparation for writing this chapter, I asked members of the group to talk about what the group means to them. Four clusters of comments emerged. First, the group offered a place apart from one's family where one could "unload" hurts, joys, pain, frustration, and hope. In a very real sense the group has become a place of confession and absolution, a place where we receive each other just as we are. Second, most of us feel that our group has become a place where we can be absolutely honest. We are not a conventional therapy group, but members seem to sense that one can be "honest to God" and to each other without any feelings of rejection or judgment or betrayal of confidences. Third, members of the group expressed a growing sense of *bonding*. Fourth, members talked about the experience of a new sense of our faith and love. Because we gather in church, the place of our

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being together is symbolic of our purpose. As I reflected upon the notion that faith and love were conceived as part of the same experience, I sensed that we were deeply into a wondrous mystery of Christian experience, that having faith means being loving. Loving means living faithfully. In the group, both words apply to the same experience.

Finally, members spoke of feelings of failure and inadequacy. In one year, two of our group died. Susan, a regular, was always very involved. She had shared with us her story of struggle and depression, often related to painful events in her personal life, and had formed a prayer partnership with one of our members. Though we knew her struggle was difficult, we all felt as well her disarming gentleness. She always smiled when, I think, she felt like crying. Coping with life was painfully difficult for Susan.

Her death was a deep shock to all of us, and we spent one entire evening attempting to deal with our feelings of loss. Members felt anger: "Damn you, Susan, you didn't give us a chance." Others experienced a sense of relief: "Finally, Susan has peace." One related a sensitive story of her experience with Susan just the week before her death. They were reading something of Evelyn Underhill's *Abba* and had spent special time with a phrase Susan loved: "Those who use the prayer, must pray from the cross" (in Roberts 1982:14). Now Susan lived in the cross eternally. Others spoke of loss, a sense of inadequacy: "How had we failed her?" Some expressed guilt: "Couldn't we have done more?" We all

felt, I think, painfully aware of our limitation and our uselessness. We experienced something of our own mortality. One among us had died.

Shortly after Susan's death, a second past member, Susanna, died. Her struggle had been a long-term physical battle with thyroid difficulties and a benign abdominal growth, which caused painful bodily discomforts. Her death occurred from a sudden aneurysm near the brain. When she had left the group months earlier, she had never really told any of us her reason. Later she and her family left the church and joined a neighboring parish. Since we had repeatedly invited her to return and share with us, we felt her death was a second judgment on our values, a sign of our lack of success. We were learning as well the difficult lesson that people who are chronically ill do die, perhaps sooner than others.

As we worked through our feelings of grief, we also felt a sense of deep achievement and peace. We had faced death close to us with tears, anger, resentment, doubt, and faith. We had grieved deeply and shared our grief. And we knew even more profoundly how much we needed each other and how loyal we felt to each other. Though limited in what we could do for each other, we reaffirmed our being in the shadow, in our little place under the cross.

Implications for Parish Ministry

Are there lessons for parish ministry to be learned in the shared experience of Grace's chronic illness group? In our being together, we have rediscovered the validity of Luther's notion of the "priesthood of all believers." The phrase has never been uttered in our meetings, but the reality of the metaphor has regularly been experienced. Here Christians meet in need and mutual grace. Here we absolve each other without ecclesial ritual. Here the word of life is spoken, proclaimed, and acted out, not from pulpit nor from vested clergy, but from each of the members. Here the Scriptures are read and listened to with a special kind of interpretation, that of need and desperation. Here the sacrament of the Eucharist is offered by the gift of one or another as bread of life, and here we practice priesthood without ecclesial office, but with faith and love.

Were parishes to learn from this peer ministry experiment, the church might abound in what contemporary Third World Catholic countries are experiencing, the "base community." Base communities are groups of simple Christians who gather to pray and share mutual need and care. They are without clerical leadership, for the most part, and they have achieved amazing results. The base community has become the front line of parish renewal in many Third World countries in both Central and South America. Out of that experience has come a whole new literature of theology and devotion (see, for example, Cardenal 1982).

Grace's chronic illness group is such a base community, a place where simple Christians grapple with profound truth. Were the church to be open to such need-oriented structures, all sorts of new, intimate communities would emerge, little churches in the larger church. Parishes open to such a paradigm of organization would probably completely reorganize their ministry. Groups based on natural interest and need would emerge as God's people took ownership of their priesthood. The anonymity of worshiping with five or six hundred believers would be balanced by the discipleship of small groupings. These ideals are, I believe, equally supported by the experience of two other groups at Grace Church: one focusing on the needs of health care professionals and one for those who have experienced deep loss through death or divorce.

The experience of Grace's chronic illness group recapitulates the insight that the most profound words of healing are spoken by unlettered saints of suffering. This is no place for emotional spiritualism or a theology of glory. One member challenges with prophetic style that Jeremiah might have envied. Still another affirms so that one feels absolutely accepted. We have gifts of listening, of theologizing, of interpreting, questioning, and probing. All these emerge in this community of mutuality.

Many Christians are acquainted with Henri Nouwen's *Wounded Healer* (1972) and with his thesis that one ministers out of one's woundedness, not one's

One ministers out of one's woundedness, not one's strength.

strength. One of the primary lessons that one learns from persons chronically ill is that healing and support can indeed come from wounded persons. I am always reminded, as I listen and observe my peers in our meetings, of Jesus' words about the "woman who loved much because she was forgiven much." A corollary is equally true: persons who suffer much seem especially adept at compassion. Were parishes to incorporate this truth into ministry, then congregations might really become communities of salvation and healing. Persons who experience long-term illness might be enlisted for regular pastoral care or visitation to hospitalized patients, and parishes might even match particular illnesses. I suspect there would be a radical leveling process among all members. We would seek to make our personal weakness avenues for ministry. We would be less prone to hide behind polished "personas" of health and allow our vulnerability to become the avenue for ministry.

Chronic illness tends to be a somber reminder of death's reality. I sense that what I experience with Crohn's disease and what my peers in our group at Grace experience are closely related to death's reality. Chronic illness regularly mirrors the shadow of death, and certain lessons can be learned only through such an experience. One learns over time to offer one's suffering as a daily ritual of worship back to the God of life and death. Offering one's suffering is a way of sacramentalizing the experience of illness. We offer our pain, our anger, our frustration, hope, faith, our sickness itself, as

a living sacrifice in eucharistic fashion. The offering is received in Christ as is all our prayer. In his suffering and his humanity, in his broken body, we offer ours and we are healed.

"May the sacrifice of our hands and our lives be acceptable in your sight" is eucharistic language and the language of illness. The offering up of one's illness really frees one to live out a sacrificial and sacramental existence. One does not have to bear the hurt, pain, frustration, anger, resentment, and most of the other feelings alone. There is but one sacrifice necessary, that of Jesus. Yet all our life is a living sacrifice which participates in that offering, so there is the ongoing sacrifice of his resurrected presence. When his spirit prays incessantly in our behalf, illness is liturgy for Eucharist, for giving one's body in Christ up for the world and each other is really the meaning of love.

Chronic illness, then, can be a school for excellence in the art of dying, and a chronic illness group a classroom for instruction in that art. We learn to die by letting go, by slowly unclasp the bonds that tie us to this life. That is painful work, best done in community. And since no one dies in any other way than one lives, we need to affirm the diversity of strategies for confronting death. The chronic illness group at Grace Lutheran Church has become a place where each of us characteristically struggles with his or her own personal art of dying. We are learning slowly to accept each person's way of doing that. In the acceptance we are learning ourselves to reaffirm our own death and our way of dying.

We never pray for dignity; we pray rather for a death honest to our character and our life, one that is offered up in our real name. My name is Stephen, and I am more clearly known and accepted in this group than in most communities where I live and work. So the friendship of my sick companions helps me face death as Stephen.

If we learn well the art of dying and if we are able to offer up our illness and our own death as a living sacrifice, then we have learned that the art of dying is paradoxically the gift of love. Chronic illness can become an academy for the abundant life. If one can face death honestly, then one is free to live with abandon and freedom. If the cemetery holds no trauma, then its mystery is revealed; only those who can die are free for living.

Chronic illness can teach that lesson. And those who are blessed by their illness do, in fact, live life with a special kind of abandonment. They know the limits of their being, so they can live life a little freer. They have nothing very solid upon which to rely, except their faith and their hope. Such folks sometimes celebrate life with a sense of joy that clearly can only be a surprise. The best and most creative response is always like Christmas, a wonderful surprise, like opening a mysterious package that one receives unrequested, but upon closer view is the gift one has always desired. Such moments are mysterious blessings of chronic disease. When at any time one discovers such wonderful surprises, that moment is filled with life, and that quite abundantly. ☸

NOTES

1. David Tracy, in *Blessed Rage for Order* (1975), correctly explains the task of all Christian theology. Christian theologians are “obliged to interpret two basic phenomena: the Christian tradition and contemporary understandings of human experience” (p. 23). There is a radical shift in contemporary theology from “dogmatic” theology (repeating the formulas of the tradition) to doing theology out of experience. See, for example, Hug 1983; Holand and Henriot 1983.
2. Norman Cousins argues for such a partnership in his *Anatomy of an Illness as Perceived by the Patient* (1979) and *The Healing Heart* (1983). Both books are filled with cogent reasons patients need to be involved in their care, yet Cousins is equally aware of the need for intimate partnership with the medical profession.
3. Martin Luther, *The Small Catechism* (1529), in Tappert 1959:345.
4. Martin Luther, “The Babylonian Captivity of the Church” (1520), in *Luther’s Works* 36:11 ff.
5. Martin Luther, *The Large Catechism* (1529), in Tappert 1959:365.
6. Martin Luther, “Babylonian Captivity of the Church,” *Luther’s Works* 36:69. Luther here is speaking of the daily baptismal sequence of dying and rising. His language is almost mystical. So the commonality of *chronic baptism remembrance* is like that of *chronic illness*, with the same potential for repentance and faith.

7. Martin Luther, Apology of the Augsburg Confession (1531), in Tappert 1959:111.
8. See Luther's sermon "Lord's Supper" (1528), *Luther's Works* 51:188–93. "A hundred thousand learned men are not as wise as one little hair of God. In the first place, therefore, learn that the sacrament is not simply bread and wine, but the body and blood of Christ, as the words say. If you take away the words, you have only bread and wine. Hence the command of God is the greatest thing in the sacrament as in the Lord's Prayer. Take hold only of the words; they tell you what the sacrament is" (p. 189).
9. Martin Luther, "Letter to Philip Melanchthon" (1521), *Luther's Works* 48:282.
10. Martin Luther, "Table Talk" (1531–44), *Luther's Works* 54:476.

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*Christ among the Doctors, pen and ink drawing by
Giovanni Francesco Barbieri (Il Guercino), ca. 1620.*

Mount Holyoke College Art Museum, South Hadley, Massachusetts

The Physician's Experience *Witnessing Numinous Reality*

Douglas Anderson

DURING MY FIRST YEAR of neurosurgical residency, I was confronted with an emotional and spiritual task for which I was not prepared. I felt that I knew the fundamentals of medical science, and I also felt that I was being trained well by gifted surgeons. They were caring and good men who communicated clearly with patients and their families and had empathy for the suffering they witnessed. However, at the university where I was trained, emergencies and crises were played out twenty-four hours a day, and I was frequently required to "go it alone."

Candace, a twenty-eight-year-old patient, presented one such crisis. Her tragic medical history revealed that she had been a prostitute and was supporting an expensive, debilitating heroin addiction. She had been

admitted to the hospital with spiking fevers and confusion. A computerized tomography (CT) scan showed several abscesses within her brain, the result of infection from dirty needles used in her drug habit. Surgical therapy was out of the question because of the number of these small abscesses. However, a diagnostic surgical brain biopsy provided information on the invading organism such that proper antibiotics could be administered. To no one's surprise, Candace eventually slipped into a coma, even with maximal intravenous antibiotic therapy. She lingered, unconscious for several weeks. Her only visitors were physicians on daily rounds, the hospital chaplain assigned to the intensive care unit, and the nurses who kept a constant, caring vigil over Candace's waning life.

Just as health professions seen as calling require a theological framework, theology requires the setting of actual experience. Theology is not only reflection about experience, but a doing, a living.

I was on call the Sunday night she died. I don't remember how her mother was located, but she arrived about one hour after death had been pronounced. The nurses and I had removed all the tubes that protruded from Candace's body in hasty preparation for this unexpected visit. The clinical neatness of the room, the dim yellow glow of the lamp through the room-dividing curtain were lost on Candace's mother. She was totally blind. The chaplain led this thin, fragile woman to the bed where her daughter lay dead. Tears were streaming from behind opaque, dark green glasses down a face that expressed unspeakable anguish, love, and despair. As she approached the bed, her hands, outstretched from the heavy sleeves of her overcoat, immediately found Candace's face. Her fingers and palms gently probed her daughter's face—its delicate features, round cheeks, and high forehead. Prayers offered by the priest concluded the five-minute visit with her daughter, while the nurses and I stood in silence.

Nine years have passed since Candace died. Even then I knew that the events of that night would remain with me not as a curious anecdote, but as a haunting, numinous reminder of God's presence. I saw in Candace's mother—along with anguish and despair—forgiveness and love. The hands laid on Candace's face yearned for the power that would heal; the hands sought complete healing of all the ills in that long chain of events that had led to Candace's death.

The experience of witnessing not only Candace's death but the deaths of many more patients sharpened

greatly my awareness of my own mortality. Although there are many ways of interpreting my experience (and certainly the experiences surrounding sickness and death), only within a theological perspective have I found hope for interpreting what I sensed was present and transcendent in Candace's room.

A Calling and a Covenant

One may view work in the health professions as a "calling." The concept of work as calling derives simply from acknowledgment and acceptance of a process of becoming grounded in divine guidance and direction. It also has to do with the daily pursuit of health and wholeness for persons and the relationship of that pursuit to the ministry of Christ. Work, as calling, is perceived in the light of the belief that human experience and divine action are connected in reality. If one stands within this perceptive mode, the work of health professionals requires theological reflection. Just as health professions seen as calling require a theological framework, theology requires the setting of actual experience. Theology is not only reflection about experience, but a doing, a living. The experience of the health professional is fertile ground for theology because it is suffused with suffering, death, healing, and new life—basic issues of theological inquiry.

Furthermore, the relationship that exists between patients and health care givers is complex. Medical ethicist William F. May has ascribed to the physician, for

instance, the roles of parent, fighter, technician, and also teacher. He also describes the “covenant” that can exist between physician and patient. This covenantal relationship includes contractual duties to patients, but it also acknowledges reciprocity: the physician is understood to be both benefactor and beneficiary. Most important, the covenant is based on a “responsive ethic” in the pursuit of health and wholeness for each person. Where there is need, let there be an intelligent, appropriate, and integrated response to it. May insists that “neither resistance, avoidance, nor the quietistic acceptance of suffering and death should define this healer’s task, but rather pursuit of health and, let it be noted, the extension of healing care in the midst of disintegrating health” (1983:127–30).

A Forum for Discussions of Suffering and Healing

When suffering and death are discussed among neurosurgeons and physicians in general, the discussion is limited mostly to analysis of the biological, medical, or surgical aspects of the story. We do not professionally discuss matters relating to a patient’s spiritual health during the critical events prior to a patient’s death. We are not usually trained to do so, nor is it expected of us. Most of us readily consult the chaplain. This is not to deny the importance of what we do discuss: medical history and physical findings, the primary concerns for

the surgeon, physician, and nurse. Also important, however, is the awareness of an experience’s psychological and spiritual dimensions for patients and their families during sickness and death, and a response based on that awareness.

In the health professions there is little time and no regular forum devoted to reflecting upon the experiences of dealing with suffering individuals. The chance for me to engage in such reflection came when the health professionals within our congregation received an invitation to participate in several discussions on our experiences in health care and life in the congregation. I reacted with both curiosity and concern about taking on new responsibilities with greater demands on time. However, I had a desire to reflect on the unresolved in my life, to connect work experiences with the gospel, and to discuss those experiences and moments that transcended my own images of sickness, suffering, and healing. Finally, a growing personal awareness of health professionals as “wounded healers” (the phrase is pastoral theologian Henri Nouwen’s [1972]) suggested the usefulness of such a forum. I wanted to talk with other healers about learning to recognize the boundaries between the natural anxiety that comes from an awareness of our own mortality and the inappropriate and even neurotic responses to that anxiety.

Our congregation appeared to me to be a community of people who knew each other primarily as fellow Christians without emphasis on professional hierarchy. The church, in one sense, was where we came “to

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mend our tattered lives,” as Abraham Heschel put it (1920:30), or in Lutheran terms, to focus attention, prayer, and praise on the Christ whose life is our salvation. The congregation is a community of people involved in many responsive activities that fill the life of the church. But congregational experience at Grace Lutheran, while much broader than worship alone, had not previously given rise to a forum for discussion about our work.

The group of ten to fifteen health professionals, comprising physicians, nurses, technologists, and a hospital administrator, met monthly in a small, comfortable chapel over the period of one year. The meetings were unique and fulfilling experiences for each of the participants. Presumably because of the intensity of experiences involving people who are sick, dying, or healing, recollections of these experiences were vivid, photographic in detail. More important, the extremity of these experiences frequently pointed to issues beyond the physical realm. Many patients were seeking not only cure and comfort but creative meanings for suffering and reconciliation with suffering as well. Had we no insight, no way to articulate the connection between medical healing and spiritual healing? The foundation for that connection, we knew, was Jesus’ own linking of physical and spiritual healing—for example, in the story of the paralytic whose body Jesus healed and whose sins he forgave (Matthew 9:1–8).

But although we had many things to talk about, the goals of the discussions were not immediately clear.

Beyond developing new friends and sharing experiences, what did we hope would come from these discussions? Three goals emerged, and the presence of our two pastor-theologians greatly aided our move toward them. They helped define and focus the meeting agenda and allowed us to concentrate on experiences and stories. The three goals involved developing answers to the following questions:

1. How can health professionals better understand their role in serving their congregation and their patients? What is the role of the congregation in ministering to health professionals as a group with distinctive needs? How can health professionals within the congregation effectively minister to one another?
2. Is it possible to articulate the conscious and perhaps subconscious images that the Lutheran heritage brings to issues of health, illness, suffering, and death—issues to which we had special access?
3. In relating our experiences within medicine, can we contribute to the understanding of a theology of suffering? Specifically, can we contribute to a dialogue between medicine and laypersons that is characterized first by the recognition of the self as body and spirit, and second by the awareness of both “the realm of tradition and

the inner world of the individual" (Heschel 1920:57) in defining reactions to and understandings of sickness and health?

The patients for whom we cared became teachers in a very real way as we attempted to respond compassionately to their predicaments. About the time the meetings began, I was asked to see a patient by the name of Rex. Rex was initially introduced to our surgical team in the hallway of a radiology suite. He was lying on a hospital cart. He complained of a rapid and progressive deterioration in the strength of his legs. A schoolteacher, husband, and father of two children in downstate Illinois, he and his family were members of an evangelical church. His wife had been the first to notice an enlarging black mole on his back three years earlier. Chemotherapy and radiation had followed the diagnosis of a malignant melanoma. Now it appeared that the disease treated three years ago had reappeared in the form of a large mass compressing Rex's spinal cord, rendering him nearly paraplegic. Metastases were discovered in other organs. Rex was slowly dying.

The spiritual strength that he showed in the face of such ultimate adversity was at first puzzling, then awe-inspiring. Rex smiled as he greeted us each morning, his courage undeterred by his helplessness and pain. His attitude was not pathologically ebullient, nor was he morose. He had somehow avoided the depression which could have so easily overwhelmed. One felt a certain reverence when one stepped into his room. We

privately questioned his wife about how he seemed to her in moments when doctors and nurses were absent (was he acting for us?); she replied that the serenity we witnessed was real and based on his confidence in God's promise for his life. He was an ordinary man, but he possessed a unique and powerful relationship with the divine. Rex's family and pastor remained constant sources of comfort and support.

Rex reminded me of another young patient, Gail. At the age of twenty-eight, Gail was diagnosed with lung cancer. She underwent surgical, medical, and radiation therapies for her disease. She later suffered severe pain in her right arm as a result of nerve irritation and scarring following the radiation. Finally, a procedure was performed in which ascending nerve fibers carrying pain information were surgically cut on the lateral side of the spinal cord. While the intensity of her pain decreased, she noticed a gradual weakening of her legs in the ensuing weeks. Unable to get clear answers from her treating physicians, she requested the help of her pastor. She and I were members of the same congregation, and I met her for the first time in the hospital emergency ward after our pastor arranged a meeting. After some noninvasive examinations, the diagnosis was clear. Gail had massive metastatic deposits of cancer compressing her spinal cord in the upper regions of her neck. She refused any further therapy, surgical or other. It was clear she would not survive much longer.

Once her condition was known, Gail began the process of accepting and understanding what con-

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fronted her. At her request, family and pastor were at her bedside frequently. As her medical condition deteriorated, I observed through discussions with her that her “spiritual condition” became purified. In her final days, the question “Why me, Lord?” became unimportant. The statement she so clearly lived out in her words and demeanor was “Here am I, Lord.” She was able to reassure us, as we attempted to minister to her, with a self-affirmation grounded in God’s grace in the face of her own death. Her acceptance of God’s providence became complete. Providence, as theologian Paul Tillich describes it, “is not a theory about some activities of God: it is the religious symbol of the courage of confidence with respect to fate and death. For the courage of confidence says ‘in spite of,’ even to death” (1962:163). Gail had transcended the physical experience of her illness, it seemed to me, by a courageous acceptance of the unknowable as well as the experiential. This confidence had as its only source God’s love: the forgiving and redemptive act of sending Jesus into the world. Gail’s courage was based on her belief that Jesus died for her.

The moments at the brink of death, for these two people, were not characterized by an evasion or denial of severe circumstances. Rex frequently reminded us that he would be a willing subject for any experimental therapy that held promise, an option that never materialized. Gail requested information about the duration of the dying process and about what steps could be taken to ease the physical suffering and pain associated with

her disease. We made every effort to answer such questions and administered appropriate medicines for the relief of pain.

These young people were tragically stricken with disease, suffering, and finally death. They seemed well equipped for this severe test. It appeared to me that Rex’s and Gail’s experiences could be traced, in part, to congregational enterprise. Particularly in Gail’s case, the long cultivation of pastoral-familial love, friendship, and trust meant that the last days of her life could be spent in a focused, concentrated, and fulfilling manner. Beatific transformation in the moments when increasing distortion and disorder of the self point toward an end of being is not common. However, for Gail and Rex there was healing of the spirit and mind; love and care were important, were needed and shared. There was a sense of spiritual preparation, of being, as Tillich puts it, “grasped by God.” Death was an experience preceded and deeply influenced by a nurturing Christian community which provided trust, communication, and people who were willing and able to be a part of this ultimate transition.

“Wounded Healers”

Physicians and nurses witness and participate in situations where emotional and spiritual support is not present. In the wards of a hospital, amidst healing and hope, one is confronted with tragedy after tragedy: new parents grappling with the shock of learning that their

baby suffers from a disease they weren't even aware existed; husbands and wives seeing each other in excruciating pain; sons and daughters searching (sometimes unsuccessfully) for the means to say a final reconciliatory goodbye to a parent. For some health professionals this extreme environment becomes a life stress that gradually depresses the spirit. One no longer possesses the will or capacity to grieve over a patient's death. Communication with patients and families becomes unnecessarily technical, defensive, cryptic, and worse, a nuisance. With escalating anger at the entire system of medical care, the demands on health care professionals, the atmosphere of defensive medicine, one risks losing the sense of awe that comes with witnessing and participating in a person's healing.

As members of the health professionals' discussion group became acquainted, we saw that each of us was grateful for the opportunity to be engaged in a healing profession. We discussed our private ways of dealing with the stresses of our work and the anxieties within our lives. For each, one of the main sources for preventive and restorative therapy was participation in congregational life and worship. Each individual had a very personal idea of how the congregation accomplished its therapy in his or her life.

During a festival concert at Grace Church, during which I had the opportunity to sing Vaughan Williams's *Five Mystical Songs*, I witnessed and experienced a powerful dimension of congregational healing. As I sang the words of the mystical poet George Herbert,

"O let thy blessed spirit bear a part and make up our defects with its sweet art," perceptions of separateness from the self, of freedom and well-being washed over me. With the self removed from the center of attention, I was able to refocus on God's spirit. The invitation, "Come to me, all who labor and are heavy laden, and I will give you rest" (Matthew 11:28), was accepted and experienced as a physical reality in the lives of many congregation members present at that service. Concrete reminders and reinforcement of this healing occur each time the congregation celebrates the sacraments and prays together. Collectively, we seek a central focus for our lives other than the individual self. In our congregation Christ is at the center of this quest, a quest for "healing" that requires faith and discipline.

Does this "healing" decrease cholesterol levels or lessen the risk of stroke, heart disease, and cancer? There is no evidence for this conclusion. In fact, one cannot even claim an increase in psychological stability or emotional maturity solely because one is part of a congregation. However, the members of our discussion group intuitively sensed the power of the congregation as a place of healing and sought in it a new understanding of the fullness of health.

Confession

Our group also discovered a most potent method for purging our spirits of difficult, heart-rending experiences: telling honest, detailed stories in which we "con-

Many patients seek not only cure and comfort but creative meanings for suffering and reconciliation with suffering as well. Had we no insight, no way to articulate the connection between medical healing and spiritual healing?

fessed” to each other the good, the evil, the uncomfortably ambiguous in our experience. In some stories the role that we played resulted in less than we had hoped and was sometimes the trigger for disaster. Each participant’s willingness, need, or desire to share experiences of such gravity was variable. Confession left one psychologically and emotionally vulnerable, a risk some refused to take. In addition, to hear confession and display the necessary response of support and love required spiritual maturity. Members had to resist the temptation to respond silently in judgment as if we were on a hospital disciplinary board. But although the exploration of the past via confessional stories brought with it an emotional tension, a mutual vulnerability, it also brought to the participants encounters with questions like these:

1. How do we interpret the role we, as health professionals, play in the history of a particular patient?
2. What about the stories we decided not to tell?
3. How honest could we dare to be with ourselves? How much of ourselves could we bare to our friends?

As we thought about the first question, we began to observe a certain ambiguity with regard to our role in the care of sick people. We tended to take more credit for the successes and more blame for the failures than

was our due. Regarding our untold stories, perhaps we sensed that they lacked the drama to grasp the attention of our hearers. But did those stories perhaps more accurately depict the average occasional lapse in caring behavior, and further, did not suppressing them suggest an insensitivity to the forgotten or unnoticed feelings of the patient or family who suffered as a result?

Confession led not only to understanding but to action. Through sharing one particular story at these gatherings, I was able to confront an important but unfinished task.

On July 4, 1986, my wife and I were visiting the home of my sister and brother-in-law. The day was perfect—replete with good food, sunshine, the sights and sounds of children playing. But the visit was interrupted by a call from the hospital urgently requesting the presence of the neurosurgery team; I left immediately.

A four-month-old child in previously good health had been napping in the afternoon when his mother attempted to awaken him. Unarousable, he was rushed to the hospital where I met him and his parents. Within ten minutes of a diagnostic X-ray examination, it was clear that Andrew’s brain was under severe pressure from an acute blood clot. Immediate surgical decompression of the brain was the only chance for saving the infant’s life. Decisions were made in an atmosphere of accelerating activity mixed with depression. The surgical procedure was briefly explained to the parents, and Andrew was immediately taken to the operating suite.

The head was prepared with antiseptic. Anesthesia gases and medicines were administered. A scalp incision, trephination (perforation) of the skull, removal of the bone flap, opening of the dura (the tissue covering the brain), and dissection and removal of the blood clot were performed in quiet desperation. Then, when we were ready to slow things down, the child's blood pressure decreased precipitously. Seconds lapsed during which we searched for an additional blood vessel through which blood could be administered to replenish the child's collapsed vascular system. The child was in shock. The heart stopped, requiring chest massage. A large vein in his neck was entered with a catheter, through which a partial unit of blood was infused, followed by another. An additional stimulant drug was given. The child, as near to death as one could be, was revived and stabilized in this thirty-second interval. The closure of the scalp wound was uneventful.

Andrew remained under anesthesia for a time as I went to the waiting room to speak with his parents. My words were something like the following: "It has been a very trying three hours and I apologize in advance if this information is bluntly delivered, but it is necessary that we communicate clearly. First of all, your child has survived the operation and is in the recovery room. It appears that earlier today a blood vessel burst on the surface of the outer right side of his brain. It evidently was part of an abnormal tangle of blood vessels that has been present, in all probability, since birth. It caused an expanding blood clot which has now been removed.

The brain was damaged by the rapidly increasing volume of the blood clot, but the damage appears confined to an area in the right lower temporal lobe, meaning that it may not severely affect your child's neurological development, if he recovers. The heart stopped for a very short time during the operation. We were very close to losing him, but he responded to injections of whole blood and other drugs. His condition remains critical. We will have to wait to see how he does in the next twenty-four to forty-eight hours. We will be in close touch."

His mother responded with a tearful smile, "He'll make it, he's a fighter." We exchanged a few more hopeful words, after which I left the family.

In the ensuing twenty-four hours, Andrew seemed to do remarkably well; he was opening both eyes and moving all his extremities. We were optimistic and hopeful. About forty-eight hours after surgery, however, his kidneys began to fail, and his lungs became progressively more congested. He died a few hours later despite aggressive medical treatment. I had no conclusions for the parents but rather shared the same stunned, flushed blankness that comes with overwhelmingly bad news. Emotionally and physically weary, I requested that the pediatricians, who had been involved in the case from the beginning, and our chaplain be with the family, who were also at the end of their emotional and physical reserves.

I never saw Andrew's parents after the events that culminated in the death of their son. I never talked to

Our group discovered a most potent method for purging our spirits of difficult, heart-rending experiences: telling honest, detailed stories in which we “confessed” to each other the good, the evil, the uncomfortably ambiguous in our experience.

them, shared my grief, or supported them during the difficult moments, days, and weeks that followed. Perhaps I shouldn't have felt guilty or concerned, but I had a lingering sense that I could have and should have communicated with that family. It was too easy for me to walk away from this tragedy, to turn my mind away from those parents and toward other matters. I had acted as if I had been more stressed, more devastated than this boy's own parents. How could I exonerate myself?

The meetings of the health professionals provided the setting in which I could face this unfinished task, and I was able to call Andrew's parents. "I wanted to apologize for not connecting with you following the tragic events in early July. Also, I want to express my deepest sympathy. If there is anything I can do. . . ." "Yes, I'm so glad you called," the father replied quietly. He continued by explaining his wife's and his present situation—the beginning of gradual recovery, their work and progress with a grief counselor, the interest they had in final pathology reports which they hadn't received. He and his wife were forgiving and understanding.

The threat of death had come upon their child quickly and unexpectedly. Priests appropriately replaced doctors as the comforters and healers. These parents, through their grief, were able to accept and respond to words of consolation and to understand that their sorrow was shared by many, including their son's surgeon. Their response unveiled their courage in spite

of their suffering. They were willing to support and aid in the healing of others. "Doctor, could it be that some good thing might be imparted to others as a result of our son's death? Can medical science learn something from it?" The question was meant specifically in reference to the burst arteriovenous malformation in Andrew's brain, but it comforted me in the way it displayed their acceptance of our human efforts, the acceptance of our "failure," the acceptance of "providence."

Though it was difficult, our group's experience with confessional stories showed us that the more honest and demanding we became as narrators, the more we learned about ourselves, our work, and our lives. Perhaps we were becoming more aware and sensitive to the importance of each moment we live, of each stranger we meet.

Our group of health professionals sought forgiveness for inadequacies, and we also realized that shouldering the entire responsibility for the care of the suffering and sick of the world was beyond our calling. There was no way for our love to be untainted in its expression, no way to keep errors or inadequacy from intruding into our relationships with patients. However, we clearly distinguished inadequacy from gross incompetence. Perhaps our group could not have dealt effectively with incompetence in a fellow participant. Forgiveness, but also knowledge, understanding, and guidance would have been required to deal with that difficult problem. But it was evident that no one in our discussion group was incompetent. Rather, we heard

from successful, in some cases compulsive, professionals who wanted nothing less than perfection from themselves and cure for their patients. We talked about those moments when, if healing for a patient's body was not possible, we sought that sensitivity that leads to communication rather than isolation, nurture and love rather than despair, healing of mind and spirit if not body.

An ironic consequence emerged from our discussion. In the process of our confession, we became aware of a certain pride in our own modesty, a sense of righteousness about the recognition of our guilt. Recognition of this potential "recursive loop" suggested to us (who were in the main not extremely familiar with confession to each other) that there is to be a beginning and an end to confession. It can and should be restorative. Its purpose is to awaken one's sensitivities to the ambiguities of our behavior and to remind one that affirmation and justification are grounded in God's forgiveness alone.

At moments in our group's discussions we sought reconciliation for past actions that was not forthcoming. In the case of circumstances that resulted in the death of a patient, there was no absolute way to reconcile or restore lost harmony. Even with a sense of being forgiven by others, the loss, the memory remained. Only the passing of time and personal resolve kept those moments from constant inner scrutiny, those moments when we felt we were a focal point around which life and death hovered, when our well-intended actions

caused the end or diminishing of a life. Here, we learned something of what it means to "bear one another's burdens, and so fulfill the law of Christ" (Galatians 6:2). It is hard to overstate the importance of this responsibility. Forbearance is a dimension within grace, a significant part of the commandment to "love one another." However, it specifically recognizes our fallenness and demands that we accept and aid each other and, without judgment, collectively share our burdens. It is possible for professionals not affiliated with a congregation or a support group to engage in similar psychological and emotional support. However, forbearance is something that professionals do not provide. "Forbearing one another" (Colossians 3:13) in the setting of our congregation is exemplified most prominently by Christ bearing the cross.

At the Cross

At the foot of this cross our group found its most important and lasting resonance. Here we experienced life, its blessings, its disappointments, its tragedies, its vic-tories; here we found a "courage to be" immune to the threat of loss of self. The communal gathering at this holy place identifies Christ's Church.

Christians in the medical profession come to the foot of the cross in a real way each time a patient's room is entered. We come to that room to offer what we can in healing, care, and comfort. We have respect for medical science, but we should not be blinded by the utopian

Christians in the medical profession come to the foot of the cross in a real way each time a patient's room is entered.

images arising from uncritical overestimations of technology's power. At the foot of the cross, one lives life with a courage that transcends one's technology, one's capabilities, one's ideology, for "awe is at the root of faith" (Heschel 1920:136). Faith becomes that state of mind which allows Christ to become manifest in one's life. It is not necessarily associated with joy, nor is it a cure for the emotions that are normal parts of the grieving process. Faith is the state of being "grasped by God." The lives of Rex and Gail can teach us more than how to die with dignity and grace. From the extremity of suffering they give us glimpses of lives lived in faith's discipline. It is clear to all that life may be interrupted in its

fullness. However, our spiritual method must prepare and ground each moment of our living in faith.

When I remember the dimly lit room where Candace died, where her mother's hands remembered her young daughter and sought to bring her back, I witness the emergence of the God who appears when our own limited perception of God "has disappeared in the anxiety of doubt" (Tillich 1962:187). It is the same God witnessed by the women outside the tomb some two thousand years ago: the resurrected Christ. For it is Jesus who experienced for all humanity the doubt and meaninglessness of the cross. At the foot of the cross, in the presence of this sacrifice, is where the true church exists. ☸

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A nurse on the night shift in the neonatal intensive care unit, Lutheran General Hospital, Park Ridge, Illinois.

The Nurse's Experience

Stories of Serving

MaryBeth T. Buschmann

NURSES TODAY WORK in circumstances vastly different from those of their earlier counterparts. Advances in medical technology have virtually transformed some divisions of nursing care, as professionals in intensive care units and newborn nurseries can readily testify. These advances, of course, have brought with them increasingly complex ethical considerations that weigh on all medical professionals but can weigh especially heavily on those charged with patients' daily care. And unlike earlier nurses, who were legally protected by either the institution or the physician in their actions toward patients, today's nurses are legally responsible for their actions toward patients, even when they are carrying out a physician's orders.

In the midst of these changing circumstances, spiritual matters are often overlooked. The spiritual needs of patients are usually left to be handled by the patients alone, by their family, or by their minister, priest, or rabbi. The religious and spiritual needs of the professional nurse, for the most part, are ignored. But the spiritual world impinges in many ways on the medical, and nurses who have a strong faith tradition have relied on faith as their guide. Some have depended solely on their faith tradition. Some have turned also to family and friends for support and guidance. But few of us have considered the congregation as a potential source of help. In recounting some of the stories that have been part of my twenty-two-year ministry as a nurse, I hope

On countless occasions the nurse wonders whether he is acting in the true interest of the patient or rather for his own comfort and ease.

to illustrate the very significant role of the spiritual in my daily work. In sharing my experiences in Grace Lutheran Church's study group for health care providers, I hope to convey a larger vision of the congregation's place in ministering to that segment of its members.

In 1967 I had the oversight of all nursing activities and full responsibility for all patients on the 3:00 to 11:00 P.M. shift at Mercy Hospital. On a floor of fifty surgical patients the evening was never slow: I had new surgical patients on intravenous feedings, dressings to check and change, surgical wounds to monitor, regular medications to administer, as well as pain medications to give. I had three or four nurses' aides to help in meeting the patients' needs—to provide a glass of water, a bedpan, an extra pillow or blanket, adjust a light, pull a drape, and so on. One afternoon during his rounds a physician examined the right leg of a patient who had an infection of the skin resembling cellulitis. Florence was fifty-seven years old, and this nagging condition had plagued her for about eighteen months. The doctor had tried everything to cure it, but so far nothing had worked. Today he wrote an order for Florence to be given as a "last resort" a toxic medication at 6:00 P.M.; he warned me that between 11:00 and midnight Florence would spike a fever at 104–105 degrees Fahrenheit. This was a wholly unorthodox form of treatment to me. After the physician left, I perused the pharmacology books at the nurses' station but could find nothing; the pharmacy could not help me either. I finally decid-

ed that I could not carry out such an order without understanding how that medication manipulated the physiology of the human body. I needed to understand why this dangerous side effect was necessary for my patient's good.

I said nothing to Florence about any of this but proceeded to call the doctor and tell him of my decision. He was furious. He said that I was undermining the trust Florence had in him as her physician and that I was calling his judgment into question. All I could offer was the possibility of having the evening supervisor administer the medication with full responsibility or of having the doctor come in and do it himself. He never justified his order to my satisfaction, but before he hung up on me, he promised that he would have my license revoked. I then went to Florence and simply told her that I would not be giving her the medication that evening. In response to her questions, I could only say that I did not understand the doctor's order. This was not an easy thing for me to do. I did not like confrontation, and I most certainly did not like the threats. Whether or not the doctor could actually have my license revoked, he could, with a physician's influence and power, see that I lost my job at Mercy Hospital and perhaps prevent me from practicing in that city.

That night I returned home with very mixed feelings. On the one hand, I knew that in principle I was correct. I was legally responsible for any orders that I carried out. Furthermore, had I carried out this order, I lacked the information I needed to make important

nursing decisions at the time of Florence's high fever. On the other hand, I had put myself at great risk. That night I prayed for guidance. I had prayed so long in choosing my profession that I was sure I belonged in nursing, but I had no idea how I was going to handle my defense the next evening. Sure enough, my head nurse and the director of nursing called me in at the start of my shift. They told me of the furor this doctor was raising, not only with the department of nursing but also with the hospital board. After I gave my explanation, I was told not to worry and I returned to work. I understood then that even if my understanding of the physician's order had been incorrect, I had the right as a professional nurse to act autonomously and to make my decision using the nursing process (which entails assessing problems and planning, executing, and evaluating outcomes). The backing of my superiors reminded me that nurses belong to a self-regulating profession. I continued to practice my profession and never saw the physician again. To my knowledge his order was never carried out on Florence.

The above provides an example of a difficult conflict, but one in which the choices in retrospect appear fairly clear-cut. But nurses confront many more ethical and moral conflicts in their daily work. These are a few of the questions that can arise in the course of following a physician's orders: Which is the right course, to feed by tube an infant unable to suck, in order to keep him hydrated (causing much pain and discomfort and putting him at risk by removing him from the incubator), or

to permit dehydration and death of the same infant because he has multiple birth defects and therefore is certain to die sooner or later? For a semiconscious woman in pain and about to die, should the nurse administer pain medication to give comfort, knowing it will lower her already weak blood pressure and perhaps hasten her death?

Nurses take an oath to do no harm to a patient; they know that a patient should be made to feel as comfortable as possible and that the personhood and human dignity of the patient must be kept intact. When these three principles, which have no priority rating among themselves, are in conflict, nurses face a very difficult decision. And of course on countless occasions the nurse wonders whether he is acting in the true interest of the patient or rather for his own comfort and ease. For instance, will the nurse sedate an elder who continually yells and screams and is disoriented, in order to have silence for himself and other patients, or will he first take the time for personal contact in touching and talking to the elder in an attempt to calm her anxiety and fear—which may not work anyway?

Deciding whether to accept or reject certain treatments (such as chemotherapy and radiation for cancer and dialysis for kidney failure) that may or may not cure or ameliorate their illness, but which will certainly cause them much pain and discomfort, remains a struggle for many lay people. Nurses can have a large part in sharing with the patient the alternatives and possible outcomes of choices, although they themselves often get all

Over a period of months or years, the nurse has given so much of himself to patients and their families that he often returns home after a shift feeling like an empty shell.

tangled up in deciding what is “right.” No matter what the patient decides, the nurse is often witness to difficult times for that individual. Thus nurses have the opportunity to become true experts on human suffering.

Nurses face two very serious problems because of this intimate and extended care: the conditions of being “burned out” and “walled in.” Over a period of months or years, the burned-out nurse has given so much of himself to patients and their families that he returns home after a shift feeling like an empty shell. As the hours pass at home, however, he experiences the heavy guilt of not having returned to Mr. Jones just to talk about the loss of his spouse and try to help him work through his grief, or of not having called the son of Mrs. Smith to notify him of his mother’s serious illness—all because he was so overtaxed that he could not spare the time. The “walled in” nurse has essentially burned out but continues at her job by hardening herself to the emotions that so often engulf her. Is it any wonder that because of stress, the turnover of nurses in an institution can be as high as 15–25 percent per year (see Curran, Minnick, and Moss 1987; McCloskey and McCain 1987)?

The nurse who stands within a religious tradition, though subject to all these stresses, can draw strength from the belief that we are ultimately “dependent upon the redemptive grace of God for healing” and that by understanding the spiritual problems of illness nurses can become the channels through which the grace of

God may work (Southard 1959). My experience in caring for Martha provides an example of this positive role of faith.

Martha was an eighty-six-year-old widow and a Christian. She was comatose and had been in the intensive care unit for weeks with no visits from family or friends. We knew she was near death, but we had no way of knowing when she would die. I took care of Martha in her last hours, as she lay in bed with her eyes closed, apparently unable to communicate. Even though she could not respond to me, I felt a bond with her, as though the love of Christ flowed through me to her. Yet I knew I was merely an instrument through which this love could reach her. I had recently read Granger Westberg’s *Nurse, Pastor, and Patient*, in which Dr. Westberg speaks of the nurse’s using prayers in the sickroom (1955:52–54). These prayers did not have to be elaborate and long; simply quoting meaningful Bible verses could suffice. While caring for Martha, I shared some of these with her: “The Lord is my shepherd, I shall not want” (Psalm 23:1); “Wait for the Lord; be strong, and let your heart take courage; yea, wait for the Lord!” (Psalm 27:14); and “Peace I leave with you; my peace I give to you; not as the world gives do I give to you. Let not your hearts be troubled, neither let them be afraid” (John 14:27). As I took her blood pressure every quarter of an hour, first with the stethoscope and finally with my fingers because it was so weak, I continued to speak to her and pray with her. (I say “with” because there was no way to know whether she could hear and

understand me, yet I believed she could.) This I continued until she died. I left my shift that day full of joy and happiness, knowing I had been a channel through which Christ and his love could speak to Martha and comfort her.

At other times, though, love seemed absent within me. I remember Carl, a five-month-old boy with a monstrously large head. Carl had hydrocephalus (“water on the brain”), in which the cerebrospinal fluid could not pass normally from his brain to his spinal cord. As a result, the fluid continued to fill his brain until his skull became misshapen and very large in circumference. A surgical procedure allows a shunt to be placed between the brain and the spinal cord to drain the fluid; however, Carl’s parents would not give permission for the procedure. His mother especially could not accept Carl and wanted him to die—quickly. Carl was not cute and cuddly, but grotesque and difficult to hold. The normal fifteen-minute feeding became a forty-five-minute period of agony with Carl. I would hold him in my left arm while I gave him his bottle and rocked him in a chair. I can still feel the pain in my left arm from the weight of his head. No family or friend could help me with my ordeal. I was alone.

There were times when I deeply disliked the child because of my own feelings of disgust and impatience. These feelings would become so strong that I would agree with his mother’s decision. At such times the love of Christ did not appear to be a force within me. Then shame would engulf me. Sitting alone in the room still

feeding Carl while other nurses were about other tasks (their feedings long ended). I would pray for forgiveness, patience, and a positive feeling for this child. I know that my faith made a concrete difference in my care for Carl. As difficult as it was, I never abandoned him. At first I could not bring myself to call that positive feeling “love.” Going back to the cross, however, allowed me to look at things differently: I was reminded that Christ had suffered for everyone and that I had no excuse for being judgmental. Eventually the love of Christ did reign amid my own sorrow, anger, and sin, and I could feel forgiveness and joy. This led me to love Carl as a true person in Christ, made in God’s image, no matter how his physical body appeared.

My faith played a role in my nursing at other times as well. I prayed constantly while working in the critical-care nursery during the night shift. Especially at night, with no other nurses or physicians moving in and out, I felt overwhelmed by the sense of responsibility. It weighed on me as I observed all the babies to make certain each was breathing. While caring for one infant, I felt I needed eyes in the back of my head for the others. At that time we had no monitors or alarms to warn the staff when breathing stopped. The pressure was intense, and I found myself relying on my faith that the Holy Spirit would move me in time to observe a baby who had stopped breathing.

Some of these examples illustrate the ways in which my faith has helped me care for, and minister to, my pa-

At night, with no other nurses or physicians moving in and out, I felt overwhelmed by the sense of responsibility.

tients. But I must confess my own dire need for ministry in some of the crises I have faced. I have needed to receive from other Christians the kind of caring and support that Christ gave on earth and that he continues to give daily to us.

In 1963, while working at Children's Hospital, I took care of David, a ten-month-old with a brain tumor. He was not expected to live. Because of his tumor, David was comatose and therefore had to be fed through a tube inserted through the nose into the stomach. The tube was inserted and then removed after each feeding. One morning after inserting the tube, I made my routine check to see that it was not in his lungs (a comatose person lacks the natural reflex that operates the epiglottis, which closes to allow food to go into the stomach and opens to allow air into the lungs). I also had another nurse check what I had done. I began the tube feeding by injecting the liquid nourishment into the tube via a syringe.

Suddenly I realized that David was not breathing. I stopped the feeding, removed the tube, and tried to stimulate him to breathe. It was of no use, so I signaled an emergency by calling "code blue." This brought the inhalation therapists, medical residents, supervisory nurses, and more. The room was full of people, all working feverishly to revive David, who did not respond. In this flurry of people and equipment, I backed up against the wall beside his bed and was forgotten. But I watched and heard all that was done for David. Suddenly the attending physician entered the room and

yelled out, "For God's sake, let the child die!" As the room emptied, the physician pronounced David dead. Now I was left alone to take care of David's body. There was no family or chaplain, just David's body and myself.

I was filled with sorrow, regret, guilt, and self-condemnation, yet I suffered alone. Even my supervisor did not comfort me, because this outcome had been expected for David. All I could do for days afterward was pray for forgiveness and believe that David was safe. I was accused of no wrongdoing, yet I needed the comfort and closeness of another Christian who could affirm my faith and point to the grace and forgiveness. What solace I found came from receiving the Word and Sacrament, the tangible means of God's coming to human beings. To this day, however, I feel responsible for David's death because I was holding him and I was responsible for his care when he died.

In this experience, I never asked for help from another Christian. Death, although eliciting many different emotions—happiness, guilt, sadness, joy, horror—still makes us feel guilty and impotent. If I were to relive this experience, I am not certain that I would know how to ask for help or whom to approach. Even now I am not always sure of exactly what I need or how to obtain it.

Over the years these experiences were stored in my memory. I was aware of them but had chosen not to bring them forward in an effort to resolve conflicts. I had

never fully shared them with another person, let alone another health professional or nurse. In fact, many of these memories burn with vivid detail as if they had just happened yesterday. I did not realize this until our congregation formed a group of health professionals. We met once a month and were guided in our discussions with probing questions from our pastors a week or so before each meeting—such questions as “What experience in your work tested you to the limits as a medical professional?” and “How have changes in medical technology affected you in your work?” and “How effectively here at Grace is Sunday absolution being connected with the failures that you face in Monday work-day life?” The main purpose of these questions was to facilitate our sharing experiences with one another and verbalizing how the congregation helped or could have helped us.

One of the concerns expressed again and again in our meetings was the difficulty of accepting death. Of course, death is difficult for all people, including Christians, but health professionals, especially nurses, must face death every day in their work. And at times a real collision occurs between medical practice and one's faith tradition. On the one hand, we know that Jesus fought death among the people he ministered to—for example, in raising the daughter of Jairus (Matthew 9:18–26), in restoring the young man of Nain to his mother (Luke 7:11–17), in raising Lazarus (John 11:38–44). However, he accepted his own death with dignity through his trust in God and rose again as the victor over death on Easter.

Yet on the other hand we meet with experiences that seem to challenge biblical understandings. A colleague related the experience of being a nurse anesthetist on a harvest team, a surgical team that removes living organs from brain-dead patients. Christians view the body as the temple of the Holy Spirit. But when the body dies and the organs are to be donated to another live human who is near death, the body is kept “alive” by life support systems in order to preserve the organs. The anesthetist monitors the vital signs of the body and keeps the life support systems in “working order.” For the anesthetist, this body appears as a live human under anesthesia; pulse and blood pressure are normal, and the skin appears a healthy pink. However, when the aorta (the main blood vessel leaving the heart) is clamped in order to remove the heart, the patient's blood pressure and pulse stop and the face of the patient turns a stark white. The body now looks truly “dead.” For a health professional, who works hard in maintaining life and who can no longer bring back the life signs of this harvested body, the experience evokes many emotions and thoughts about being a part of this patient's “death.” All the rationale in the world, including how the death of this individual will prevent the death of another, does not remove these feelings; they may haunt the health professional for days, months, even years. It was important for this colleague to be able to share such feelings in our group.

Health professionals have an unusual opportunity to see how patients face death and to participate in this

To this day I feel responsible for David's death because I was holding him and I was responsible for his care when he died.

learning process with them. Along with others in the group, I found I had several stories to share concerning this experience.

One was my memory of a thirty-five-year-old patient with multiple sclerosis. Mindy was a self-confident career woman on her way up the corporate ladder. She knew that multiple sclerosis progressed in a series of exacerbations and remissions, but that decline was inevitable—a decline that would in her view be socially unacceptable. She sashayed about the nurses' station in a beautiful peignoir holding a cigarette and a glass of water and saying, "Well, I'm going to go out in style holding a cigarette in one hand and a martini in the other." There was total denial on her part during this early period of her illness. She needed time and support to work through her shock and grief, but I was too inexperienced to recognize this or to know what to do about it. I only wanted to crack her shell and be able to share my faith.

Another experience that I shared with the group concerned a patient who inspired me. As part of a society that worships youth and beauty, I shared its assumptions, even though I was able to speak otherwise. Then, as now, I truly believed that we are the children of God, made in God's image, that our bodies are the temple of the Holy Spirit, and that we can have eternal life through Christ. My faith, however, was in direct contrast to the deepest feelings that arose in me when I confronted some of the real bodies that belonged to very specific individuals. The time I spent with Phyllis

changed my attitude so that it aligned with my faith.

Phyllis, forty-six years old, had had several operations to remove parts of her body overrun with cancer cells. She had already had a bilateral radical mastectomy (removal of both breasts, some muscle tissue, and some lymph glands), and when I met her she was recovering from a panhysterectomy (removal of all internal reproductive organs). I found it very difficult to accept such "mutilation" of her body and was most surprised to find Phyllis in good spirits. She was a small woman about five feet tall and about a hundred pounds. She was not particularly pretty, but her personality stunned me. Not only was she happy and positive in attitude, but she was also so feminine and petite. It was impossible not to like her. Several things about her puzzled me. How could she be so feminine with such a strong personality? How could she accept what had happened to her? How could she be happy knowing her body would probably succumb to the cancer in death? One day I asked Phyllis these questions, and her answers have stayed with me. She, too, had a strong faith, but her basic attitudes agreed with her faith. She told me that her cancer could never separate her from her faith in Christ and that through him she found joy even in her illness. She went on to say that after death her body would once again be perfect in Christ.

From Phyllis I learned that sometimes my faith has to rise above my feelings. Even in times of grief and depression, it is still possible to experience joy in Christ. Phyllis wasn't always lighthearted—some days were

very difficult—but that didn't stop her from being positive and cheerful. I envied her faith and prayed for forgiveness and a stronger faith for myself. I also prayed that I would not focus on physical anomalies or lack of beauty, but would be able to see Christ in all people and to view others as distinct individuals.

The telling of our stories in the group of health professionals was not an easy task. As with any other group brought together for the first time, it took a while before people felt comfortable. The process was more complex in this case because our identities and roles with each other revolved around the congregation and its life of worship, meetings, and social activities. Although we may have known that some members of our group were practicing health professionals, we had never before confronted each other with our identities of nurse, physician, hospital administrator, and so on.

Health professionals are seen or traditionally have been seen by society as infallible. As a result, we tend to present the facade of infallibility to each other. What if the group did not agree with a decision we had made in the past which could no longer be changed? We would then be seen as less than perfect and would lose face as a professional. However, through struggle, we did develop a bond of trust through our Lutheran tradition of grace, forgiveness, and acceptance. When we faltered in our storytelling, the pastors enabled us to continue by their encouragement. We sensed that we were in a "safe" environment where we would not be judged or face the threat of litigation. In private ways, we had

shared the benefits of Word and Sacrament weekly, but never before had we been able to unburden ourselves with others who understood our situations and came to us with empathy. As others slowly began to tell their stories, I found myself remembering old experiences and relating them. This was a new experience in sharing the connection between my faith tradition and work world which had previously remained private.

I do not mean to paint a picture of complete harmony. At times I became very angry because the pastors' questions frequently seemed to invoke a "one-up-manship" among the group. Who could give the most sensational or heart-rending story? I felt that my daily work was not producing these sensational stories. How was my struggle, my feeling of failure, my loss, and my sense of incompleteness ministered to by these meetings? One person attended these meetings only seldom, perhaps just once. She came, told a shocking story, left, and was not seen again. I know that the telling of her story did not help her. Some others in the group also dropped out. This was very understandable, because what we were about was not easy. Perhaps their burdens were such that they could not take on this project at this time in their lives. Why, then, did the group help me so much? Perhaps because I trusted the group. Perhaps because they also told their stories and supported me when I told mine.

Because errors of the nurse or physician can be life-threatening to the patient, many nurses and physicians live in constant fear of failure. Many times, though,

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there is no right or wrong decision; the nurse or physician cannot shoulder the blame for every failure of the patient to heal physically, mentally, or emotionally. Being able to share experiences with the group in this environment and to share the grace and forgiveness of Christ was most supporting and uplifting. It was comforting to receive from each other confirmation and to sense that we were not alone in finding ourselves in situations of risk. We health professionals are as fallible as any other human, and we are a part of the Christian family, specifically the congregation.

It is difficult to separate my identity as a nurse from my identity as a member of Grace Church because the common thread through both is my faith. In *Our Calling*, Einar Billing expresses that idea better than I can:

My call is the form my life takes according as God Himself organizes it for me through His forgiving grace. Life organized around the forgiveness of sins, that is Luther's idea of the call. . . . But as [the Christian] goes quietly about the duties of his calling, he does so in no spirit of resignation from every attempt to attain the ideal, but in a faith that for the grace of God, which is new every morning, nothing is impossible. . . . To say that work becomes calling when the light of the forgiveness of sins falls upon it, is the same thing as to say that work becomes calling when its ultimate goal no longer is merely struggle for existence but the Kingdom of God. (1955:11, 23, 24)

I was made more aware of this during the year that our health professional group met at regular intervals. Never before had I experienced such a forum for the telling and hearing of people's stories. Never before had I focused on my profession within the context of a congregation. Once we became comfortable and trusting of one another, our time together was a healing experience. In the light of our faith, we shared. Being able to share past and present experiences with fellow members of Grace Lutheran Church who were also health professionals helped me work through many of my feelings completely. I found myself able to grapple with questions about my identity as a nurse and member of Grace and about what my profession and congregation mean to me.

I have never felt my faith and work to be so integrated as I do today. My experiences with the health professionals' group helped me to see my profession differently and in a more positive way. I need not be alone any more. My reflections have continued to surface, even after the meetings ceased. The difference now is that I am not afraid to meet these memories. In addition, I now know individuals I can turn to if necessary to work through the past or the present, and this can be done with the common denominator of faith in Jesus Christ. ☺

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For Sophie, Bald in Church

*The others on whom cancer
also closes in wear wigs or scarves
but your head is bare*

*and smooth as a peach.
You wear it cleanly
and there is no Auschwitz*

*agony in your eyes although
you also know that other type of
baldness sour and silent. But now you*

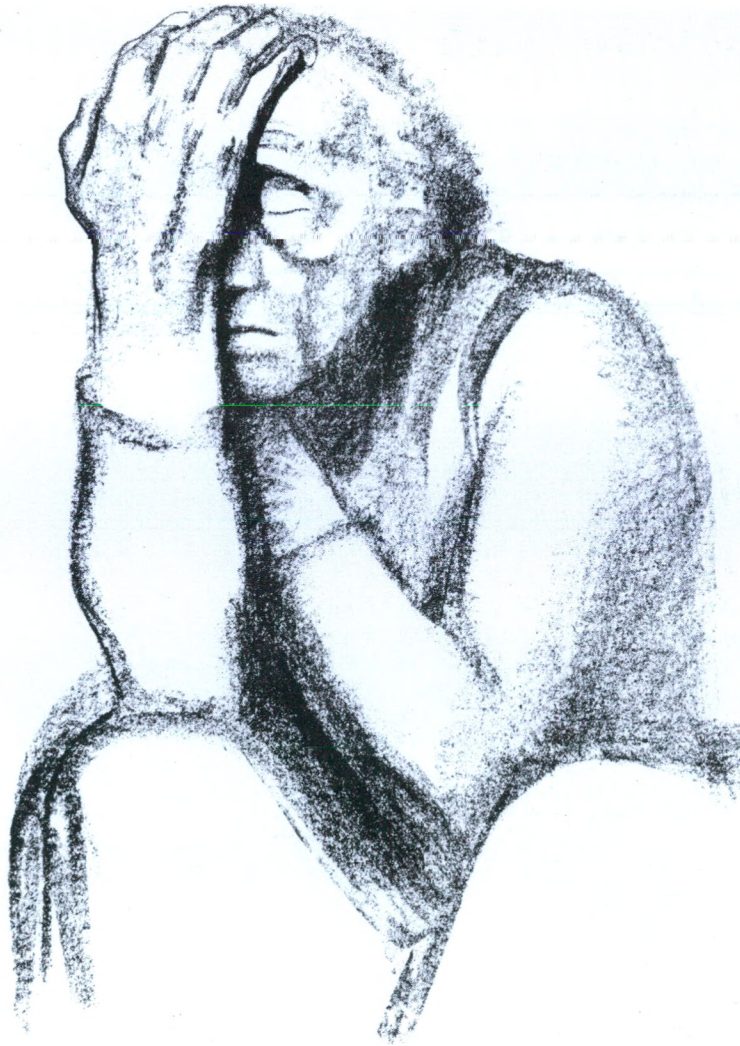
*ask about what happens later—
if the soul hovers in the out there
floating in dreams waiting*

*for the body to catch up.
And we in our habitual pews
sit behind you and see the cross*

*through the penumbra of your
head—naked as an infant
still curling into its mother.*

Jill P. Baumgaertner

Poem reprinted from *Ariel* 6 (1987) with permission. *Ariel* is a publication of Triton College, River Grove, Illinois.



Woman Thinking of the Past, *lithograph by Käthe Kollwitz, 1920.*

National Gallery of Art, Washington, D.C., Rosenwald Collection

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