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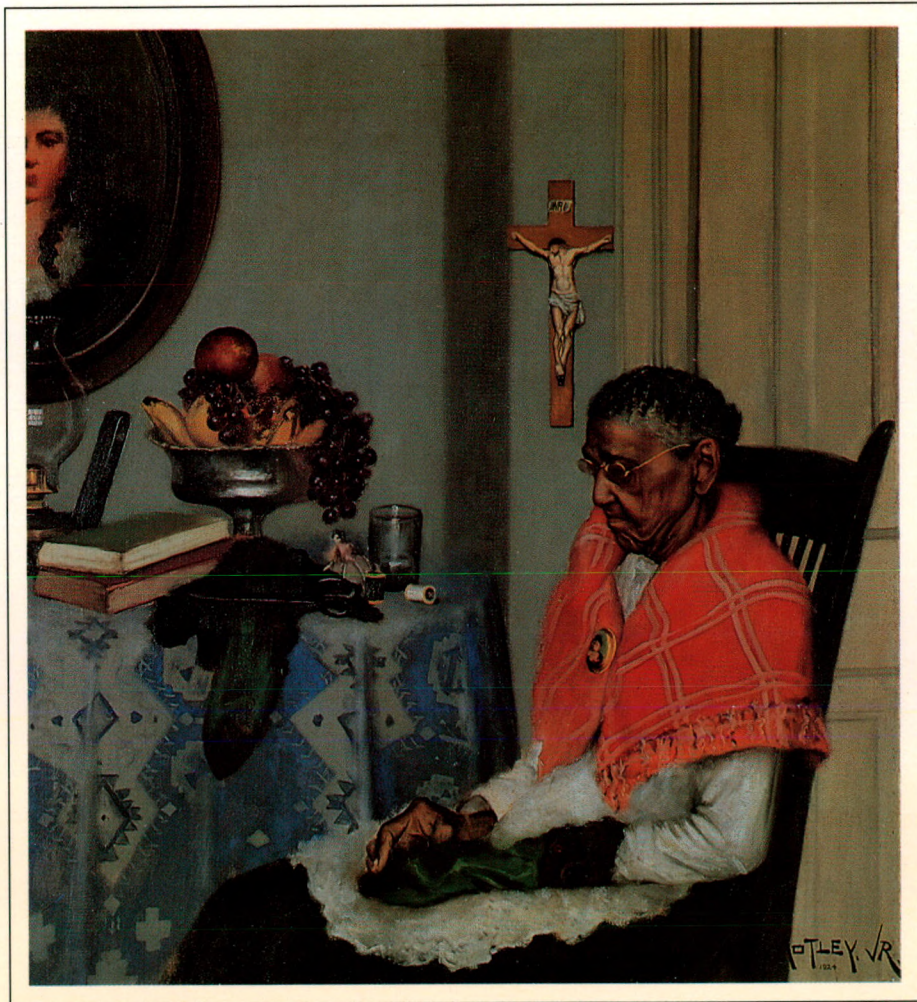
Second opinion: Health, Faith, and Ethics, 1993, V19 N1, July

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S E C O N D O P I N I O N

HEALTH • FAITH • ETHICS



Petitionary Prayer • Aging and Identity • Death and Dying Well in the Orthodox Tradition

A publication of the Park Ridge Center for the Study of Health, Faith, and Ethics

COVER

Mending Socks. Oil on canvas by Archibald John Motley, Jr., 1924.

Collection of Ackland Art Museum, University of North Carolina, Chapel Hill.

S E C O N D
O P I N I O N

HEALTH • FAITH • ETHICS



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The Park Ridge Center exists to explore the relationships among health, faith, and ethics. In its programs of research, publishing, and education, the Center gives special attention to the bearing of religious beliefs on questions that confront people as they search for health and encounter illness. It also seeks to contribute to ethical reflection on a wide range of health-related issues. In this work the Center collaborates with representatives from diverse cultures, religious communities, health care fields, and academic disciplines and disseminates its findings to professionals and others interested in health, religion, 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.

SECOND OPINION

Volume 19, number 1* • July 1993

A publication of The Park Ridge Center for the Study of Health, Faith, and Ethics

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INITIAL COMMENT

Inwardness

Innerlichkeit. Theologian Joseph Sittler used the word in conversation with a young student who was interviewing him about the peculiar loneliness of the very aged. That student, Kay Bessler Northcutt, made it the theme of her article, and it became a unifying strand as we selected and arranged the essays in this issue. The “health, faith, and ethics” implications of that theme became obvious to us, just as it seemed to us to have been overlooked in much of the literature.

Our dusty German dictionary defined *innerlichkeit* as “inwardness; subjectivity; subjectiveness; intrinsicalness; cordiality.” Professor Sittler never used words with single meanings if he could find one to carry many. In his near blindness and deafness, he had occasion to sit alone and turn such a word over and over in his mind, letting the many meanings crowd each other before the single word came from his lips. In the present context, “inwardness” serves best.

Out came the English dictionary, where we learned that the spin Sittler was giving the word was not an exact match for the standard definitions, though it was close to several. The standards include “the inner part,” “the inner nature,” “relation to or occupation with what is inward or concerns man’s inner nature, as opposed to occupation with externalities; spirituality.” Fine. Except that Sittler, who positively cultivated spirituality, the inner nature, was here treating also the negative side: *inwardness* meant aloneness,

the unwelcome side of solitude, the loss of the circle of friends with whom one compared notes. (He does not mention it, but for years he kept a vigil at the bedside of his wife, who suffered from multiple sclerosis and could in no way be a conversation partner for numbers of years.)

In *Second Opinion* we aim to reach professionals in medicine, religion, and the academy and also dedicated nonprofessionals beyond those spheres. Everyone who has been a patient, a sufferer, knows the terror of isolation. Everyone who deals with the isolated, the suffering lonely, knows how important it is to reach out to others, to the Other. This issue points to some of the reachings-out, the social dimensions.

For example, in respect to the “capital ‘O’ Other,” those who are theists—which means over 90 percent of this nation’s population—recognize that the language of prayer gets voiced with special intensity at times of illness or threat. In an article which inspired in us an “I never thought of it that way before” reaction, Donald Capps revisits prayer as an overcoming of isolating inwardness, a continuing conversation involving “coorientation” of self and Other. Readers who are not Christian will gain an understanding of what goes on when Christians who are ill pray “Thy will be done,” and they, along with Christian believers in our readership, may learn why the language of “Thy will” need not be a last word of defeat or resignation.

However universal its reach, faith comes in particular forms. We prefer to have Jews hear the voices of Muslim or Hindu or Anglican spirituality rather than to assume there is a vague space halfway between them. This time, therefore, we hear the witness of an Eastern Orthodox Christian ethicist, Vigen Guroian, who lets us overhear the language of his huge (but to most Westerners, still remote) believing community. His essay also deals with inwardness—in the case of Baby Rena's parents, an inwardness that has turned to a "spiritualism and otherworldliness" and needs countering. He makes it clear that the reaching out of those who search for meaning or who are self-enclosed in suffering requires personal response and not merely a set of theological propositions.

From the inward, reaching out: Tom Welsh speaks for those who have to await results of a medical probe that may be crushing. He does it by recalling an incident of long ago, one that informs his more recent worries and brings back to mind a most disturbing event in which a Japanese boy outside his ramshackle cave-home reaches out to three American merchant seamen surveying the devastation that was Hiroshima.

How can we prepare physicians to understand the circumstances of those with whom they interact professionally, those who are ill, who suffer? How can they deal with both the negative and positive sides of "inwardness," the isolation and

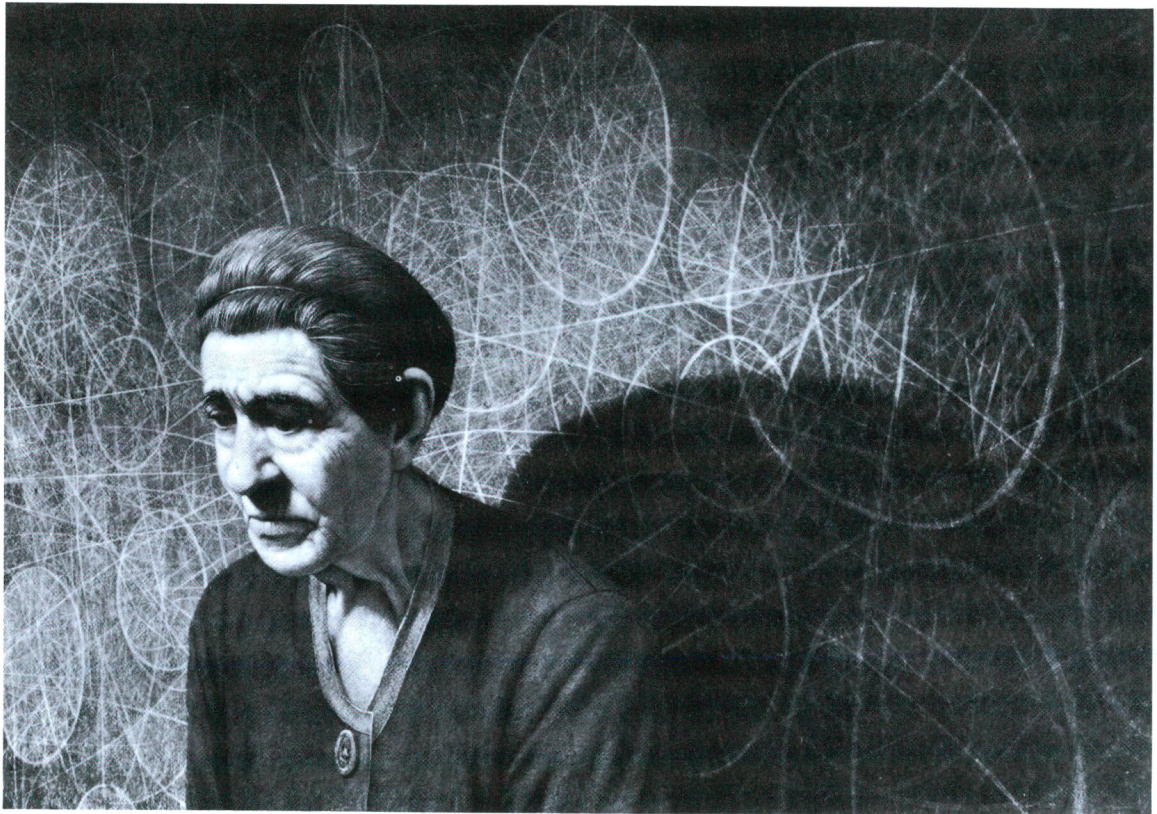
the spirituality? Mary G. Winkler shows how the visual arts promote empathy and alertness; one does not need to be a medical student or a physician to profit from her elaborations.

Sir John Templeton, subject of the current interview, is very much at home with the world of what the dictionary calls "externals": his has been an enormously successful career in the world of finance and investments. But as the interview makes clear, he lives spiritually far from those who appear to be confined to a world of self-centeredness and competition. He has made a parallel career by encouraging a "reaching out" across the boundaries of hitherto isolated and self-enclosed communities marked "Science" and "Theology." He elaborates how and why he has done so and why he would have others follow the example.

Innerlichkeit, "inwardness," we see, can be devastating and healing alike; but it finds a balance in the reaching out, the *Äusserlichkeit* described in this issue. We find it in the counsel of Sittler, the prayer that Capps advocates, the search for meaning and belonging described by Guroian, the reminiscence of Welsh, the art used by Winkler, the catalysis of Templeton—and the imagination of our readers.



Martin E. Marty



Chrissie. Egg tempera on panel by Robert Vickrey, c. 1960.

Robert Vickrey/VAGA, New York 1993.

Aging and *Innerlichkeit*

My Conversations with Joseph Sittler

Kay Bessler Northcutt

All wisdom is contemplation of death.
—Anaximander

CHRISTMAS 1982, HOME AGAIN to sweet, ugly Oklahoma after an infernally long 13-hour car ride of encapsulated exile—a return following my longest time away. Leaving the stale air of the car, I stepped onto the familiar snap of brittle, thick-veined oak leaves, inches deep everywhere, breathing deeply the biting, sharp smell of them, and then the aroma of a fire. Dad had the yule log burning already . . . and then the open door—Momma rushing out—I nuzzled in closely for the smellfeelsoundbeat of her.

A deep wash of sorrow swept through me more quickly than I could comprehend. Something was different. Something was changed in a way that invoked a quiet terror. In the first moments of conversation, searching her face, I saw what had made me afraid. My mom had aged. Her face bore the truth of oldness, and of our eventual separation from one another through death.

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Of course, I had known this truth for years, but the physical evidence written on her face forced me to enter more deeply its reality.

Upon my return to my own home in Iowa, I began a relationship with a care facility for the aged and dying in order to face my fear. I became the ad hoc music therapist and piano player for a biweekly sing-along session.

The first week, as I walked through the door between those who are independent and those who are not, I unhappily met with the smells of a nursing home: the faint, pervasive scent of urine; old, warm food smells left over from lunch; a thick screen of disinfectant and cleaning solutions. Waxed floors shone under the racket of buzzing fluorescent lights. It was surreal. All my senses were bombarded: smell, sound, sight, feel—the last because it's always smotheringly hot in nursing homes in the winter.

I made my way through the brightly lit air to find Debra, the recreation director. She had gathered the more able residents in the common area, with 30 wheelchairs arranged more or less around the piano.

She provided music for me and word sheets for

the residents. It was grim. I played popular songs of the 1920s, while all around me murmured the babbling of minds at loose ends.

But I kept hearing one enthusiastic response! Someone was whistling perfectly the tune of whatever old song I was playing. Whenever I turned around to see who it might be, silence fell. But whoever was doing it was obviously having one fine time, and it kept me playing.

For some reason—the determination to face my fear? the whistler?—I returned for the next sing-along and the next and the next. Slowly, the old ones came out of their somnambulance. Our sessions became lively encounters, complete with wheelchair dancing!

At some time in my third week of music making with the old ones, I realized they were hungry to touch me—and be touched by me. I also realized that many of these people felt a human touch only when being moved from point A to point B—or when being cleaned. A caress for its own sake was rare.

At first I found it difficult to touch. Aging skin—so translucent and silken—was a scary thing to touch. To touch it was to touch my own mortality—or somehow to jeopardize my own health and youth. But I did touch. And then each music hour began with my going to each of those who had assembled, inquiring about health and loved ones, all the while holding and stroking a cheek, a hand, an arm. I became comfortable with old skin's frail pinkness.

As I opened up to these people, my sense of history became dramatically altered. It was not entirely unthinkable, for example, that some of these folks (who are now in their hundreds) had parents who were alive when Beethoven was writing. I had a link to history—I knew someone whose mother could have known Beethoven! Time shrank, became

digestible. It had meaning; I fit into it. History was not a vacuum but was accessible, sensible, at my fingertips.

Seeing the limit of life called for a new way of living. How will I spend myself today? What part of me should I conserve for tomorrow? What will I do today that will regenerate itself when other areas of me are spent from old age? I had a new divining rod for what was important, what was worth working for, and what was worth having in life.

For me, the experience of touching and being with the dying (like no other experience I have ever known) caused me to feel my own history, person, and self concretely connected—in astounding new ways—to life, to community, and to God.

When we live our lives with the old ones—now dying—we see clearly the frailty of human life. We become more likely to live, in

Goethe's words, with "reverence of the past as the basis for all sound progress" through being *connected* to the past, that is, to the aging, dying ones among us. In embracing that fragility, we are welcomed back into the dazzling wonder and sharp pain of life. We uncover a sacred reverence for life in the contemplation of its end.

Many times, leaving the nursing facility, I wanted to stop the world, make it pay attention. I wanted to wrestle every human life on the planet to a complete standstill so we could admire in silent, anguished wonder the passing moment that each human life is.

Could it be that aging and dying folks had the key to unlocking life more abundantly? Could my sense that disinheriting the aging is a violent act against personal and communal formation be true? What effect does the invisibility of aging in our society have on our God-relationship, on the telos of our lives?

Aging and death are central to living life "more abundantly"; our modern experience of alienation is deeply connected to the invisibility of death and aging in our society.



Portrait of an Old Man in Red. Painting by Rembrandt van Rijn, c. 1652.

Collection of the Hermitage Museum, St. Petersburg. Photo: Art Resource, New York.

I left Iowa and the piano to bring my questions and convictions to divinity school. In the first 15 minutes of the first course of the first quarter of my studies, Martin Marty interrupted his syllabus exegesis to say, "If there's one thing you must do it is to introduce yourself to Joseph Sittler and spend some time talking with him."

Two years later, I saw that Joseph Sittler was scheduled to speak in the "Last Lecture Series." It jostled the memory of Marty's injunction. Grudgingly, I bundled myself up against the relentless Chicago winter (if an 80-year-old could, *I* could) and attended the lecture. Stunned by the rush of poetry, prophecy, and wisdom that was Joseph Sittler, a previously suffocated part of me caught its breath.

Several months later, Marty handed me a copy of Sittler's article, "Reflections on Aging," in which he asked, "Why is it that the people doing research on aging are not looking at what the *aging* are saying about aging?" (1986:131). "On the matter of aging, my credentials are existentially magnificent: I am eighty-two years old. I am also a professor of theology" (1986:126).

I made an appointment with Sittler and asked him to participate in my senior ministry project. Excerpts of our conversations follow.

WILLIAM BLAKE WROTE OF SEEING a "world in a grain of sand." My conversations with Sittler about aging-toward-death rest *on* Blake's insight and *in* this conviction: Through examining the vital detail of the particular—the grain of sand—we are given the gift of the universal.

The first time we met, I told Sittler I had come to hear what he—an aging person—had to say about being old and about aging.

He retorted that if that was the case, I had better "talk more slowly," "enunciate consonants more percussively," and sit in the chair on his left side so I could speak directly into his "good ear." During the better part of our first conversation *he* interviewed *me*. When he discovered that I was a pianist, that I preferred Palestrina to Handel, and that Emily

Dickinson was my Psalter, Sittler barked at me to open my notebook and "*listen*."

He began, eyes closed, resting comfortably back in his chair, speaking rapidly in complete sentences as if it were an essay he had memorized long ago:

"The particular quality of loneliness in aging is utterly different. It persists despite the very warm closeness of family and friends. It must be analyzed, and I've been trying to do it. Despite my six children and wife, it [this utterly different quality of loneliness] is not soluble in the ordinary ways—in friends, wife, family. This qualifies what we mean by spirituality. If it deepens at all, it is done in the face of that loneliness.

"Call this paper you are writing 'Aging and *Innerlichkeit*.'* Talk about the inwardness, the loneliness. Say you had several long conversations with an old duffer!

"You see, the old experience a massive accumulation of problems: unsolved issues, needs—national and familial—and at the very time when they are dubious about the adequacy of a single simple solution . . . there is longing for such a solution.

"I was thinking . . . here I am in my eighty-third year . . . dangling, unresolved . . . about how many things I'm still uncertain.

"I do not—have not in my lifetime—solved the problem of God. I only know that to try to escape is unfaith.

"How does one end life in enormous uncertainty and still remain with a religious center? I'm going to wrap it up in the last chorale of the *St. John Passion*, hand it to God, and say, 'You take it from here.'"

Sittler and I ended this conversation exchanging favorite moments of poetry and music. After discovering our mutual admiration for Palestrina, Sittler quipped, "When Palestrina makes music before the Lord, I listen. But with Handel—and this has

**Innerlichkeit* literally means *inwardness*, but the word expresses far more—an apartness, a shifting of the center, a conscious turning away from the exterior world to the interior.

been especially true in my old age—it's too English; too all hallelujahs and confidence!"

DURING OUR NEXT CONVERSATION, I asked Mr. Sittler to describe how the loss of physical abilities, specifically his loss of sight, affected him:

"As visual input decreases, you more intently attend to what you *remember*. You do not freshly add, but you more deeply reflect. So there comes a time when reason is very slow. You remember what you can't see exclusively—but it is totally transvisual. In this shift to remembrance, you reorganize things in your own mind. Your experiences—and things which might have been neglected in the pool of experience—you summon to the surface.

"About a year and a half ago I was asked to speak at a wonderful home for old people run by the Methodists. I didn't know what to say to them because they were in my state—many of them losing vision, losing hearing. Among the things I could talk about, I talked about this fact—and it is a fact: the usual social scientific analysis of how to deal with aging is in some ways insensitive. I call it shuffleboard-school geriatrics: keep 'em happy; keep 'em sort of sedated by entertainment; teach 'em how to play bridge, poker; take 'em on bus trips around the town—diversion, entertainment, digression.

"The usual investigation of geriatrics by social scientists misreads certain aspects of the problem. The surface character of their investigation does not allow for the interior aspects of aging: loss of identity, waning of memory, loss of role. What interior role do you have? You know it's characteristic socially that the first thing you say to someone after meeting is 'What do you do?' Well, when you don't

do anything any longer in American society, who are you? You're the residue of a ruin.

"One of the saddest things of aging is the blurring of identity. Why is it that we feel it slipping away? The reason is that you are defined by your relationships and when *they* decrease, who you are

becomes vague. One's identity is the deposit of experiences, relationships, and roles. And when these are taken away, you are not sure who you are anymore. Because no job is designated, you have absolute power to choose what you will do every day. Who are you when there is no 'must' or 'have to' or 'this is my job!'? 'I'm a machinist.' 'I'm an accountant.' And this means the formative forces that constitute a person's mature identity are lessened. A

person's self is diminished. Their image of themselves is without sharp lines.

"In talking to these old people, I thought I would try an experiment. I would *remember* them back into identity—cause them as I spoke to remember themselves back into identity. What I did was this. I told them that as I talked about my youth, I wanted them to think about their own youth. So I talked about the days I was a kid in southern Ohio—about what a little kid does. These old people started to cry, but it was not from grief. [Tears swiftly cover Sittler's face.] To cause them to weep was not a sad thing. They went out of the room talking to one another as they never had before. It was a recovery . . . I think I've got hold of something here *very* important, for the interior aspects of aging are loss of identity, waning of memory, peril of loss of role."

I mentioned the experience of utter nonbeing that Jesus had on the cross in Mark's Gospel. Could it be analogous to the absence of *being* that aging and dying people experience?

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The Old Servant. Painting by Edwin Augustus Harleston, c. 1935.

"Yes, you're right. If I ever preach again, it will be on that text: the fulfillment that *is* his descent into hell. That is when God himself goes into the hell of a dangling uncertainty of God himself. So that the incarnation is not just a happy baby—but the death. He is with us *absolutely* in our death, in our abandonment."

Referring now to the first part of our conversation, in which Sittler had described the changes in self-identity that come from changes in relationships and roles, I asked if a substantive difference also occurs in one's relationship with God as one's life turns toward death.

"A transfer does take place. At first, your relationship to the ultimate and penultimate becomes less clear in the silence and the solitude of aging. You have to dig back through popular forms of religious reality: church suppers, fellowships, hymns. That from which it all sprang becomes the fountain for your reflection.

"The center of your faith becomes a matter of reflection, and the more social and communal forms of celebration give way to the introspection of piety, in the right sense.

"As these [more social forms] wane, or as you can no longer participate in them, it is the fundamental ground of all this that moves back to center. Your God-relationship becomes an absolute one. So it may be that certain of the more profound meanings of grace become available to you only when you are divested of the penultimate meanings."

I inquired if discerning the penultimate from the ultimate is a central task of aging.

"With old age, one is forced to go in that ultimate direction, whether you want to or not; out of religious sensibility you move yourself in that direction. The grid in life—in which you live—grows smaller, and you're forced in the direction of 'whom do we have but Thee?'

"The loneliness isn't a pain that is totally painful. I am not necessarily miserable in my solitude. I haven't really come to the point that I can't *en-vision*—nor do I think I ever will. My mind is so peopled with those I have known and imagined—in

literature, history, religion. When eventfulness stops—as it does in old age—one must turn to what has been retired to the bank account of the memory. I will never be troubled by absolute loneliness. I have such a sticky memory—I can write a check on Shakespeare and he'll cash it!"

IN OUR FINAL CONVERSATION, SITTLER'S HEALTH was declining. I brought him a handful of the brightest, reddest leaves of the fall. He brought them within an inch of his good eye—as he called it—intensely concentrating on the color, shape, size. He told me he could "almost see the red" in the brightest leaf I had brought him. He picked up the leaves and passionately smelled them. He thanked me for bringing fall to him. I began our conversation by asking him to speak to me, a young minister, about spirituality and spiritual discipline.

"First of all, I would say spirituality cannot be created because it is already there. It can be *evoked*. The possibility of spirituality is given in the creation. 'He breathed into—and man became a living soul.'

"The possibility of human spirituality is a human endowment. We must find a discourse that will awaken the sleeping spirit like a fire alarm—make them see what's always there. There is cognition by amazement.

"And they were amazed, and they said, 'Behold! How she [Mary Magdalene] loves him!'" A priest or a preacher, a minister, must declare the word of God so that it intersects the latent spirituality of life. A minister can—through the obvious delight and wonder of the spirit in her—awaken the sleeping ones to the absence they feel.

"Still, spirituality cannot be built by the sheer intention to do so. It thrives in the soil of imagination, curiosity, eagerness, zest for life. And it can also come from a tragic sense of life. But not without a profound capability of feeling—Unamuno and Shakespeare know this, and Kierkegaard."

Then I needled Sittler, questioning him on the joy of baseball: Must we leave behind the secular

behind on our spiritual quest? If he had to choose between the World Series and the Chicago Symphony Orchestra playing an all-Brahms concert, which would he choose?

"Brahms we will have with us always. This is *not* the case with the World Series. You must learn, as I did, to love them both. There is no conflict between Brahms and baseball, between the spiritual and the secular. Aquinas was very good on this point: Grace does not destroy nature but perfects it. God never diminished my love of the things of this world."

The conversation ended with our reciting poetry to one another. I read Dickinson; he recited a Shakespeare sonnet. In what would be the final time I spoke with Sittler before his death, he dismissed me with two commands: "Kay Northcutt, go enjoy yourself and *don't regret it!* . . . And take the leaves back where you found them . . . they'll make good humus."

SITTLER HAD GIVEN ME THIS ADVICE in our first conversation: "Listen to your spirit no matter how it sounds—and see what it's talking about. Begin theologically, and one thing will become more important than another. Method grows out of that interaction."

For me, Sittler's method opened the way to one pivotal insight: aging and death are central to living life "more abundantly"; our modern experience of alienation is deeply connected to the invisibility of death and aging in our society.¹

Writing on the moral dimension of death, pastoral theologian Bonnie Miller-McLemore notes

that "the problem of death is not merely one of finitude . . . but involves questions of human obligation in relation to others and to one's world" (1986).

With the removal of death from our intimate lives, we have lost the vital ability to touch bottom—and, in turn, to sense which way is up. In the disappearance of death, "obligation in relation to others and to one's world" becomes suspended in a vacuum. The possibility of right relationship is eclipsed, and with it, life more abundant.²

Again, Sittler: "I faced death early in my life, not because of any wisdom of my own, but because I'm so confounded old that I was just a child at the time of the great influenza epidemic of 1916 and 1917. Three of my friends, with whom I played Saturday-morning baseball, died in that epidemic. So death hit me straight in the face when I was about ten years old. In my own ministry I disobeyed the American way of silence about death. . . . For those with an interest in the issues of the aging, I end with an admonition: . . . See that you come to terms with death while living, and not with a shock when you are dying" (1986:132).

Participating in the aging and dying of those around us "shocks" us into life more abundant.

Sittler instructed me to be "vehement as hell about the perfectly obvious." Go. Go to the aging. Go to the dying. Sit in the chair next to the "good ear." Enunciate consonants percussively. *Listen*. Remember back into identity.

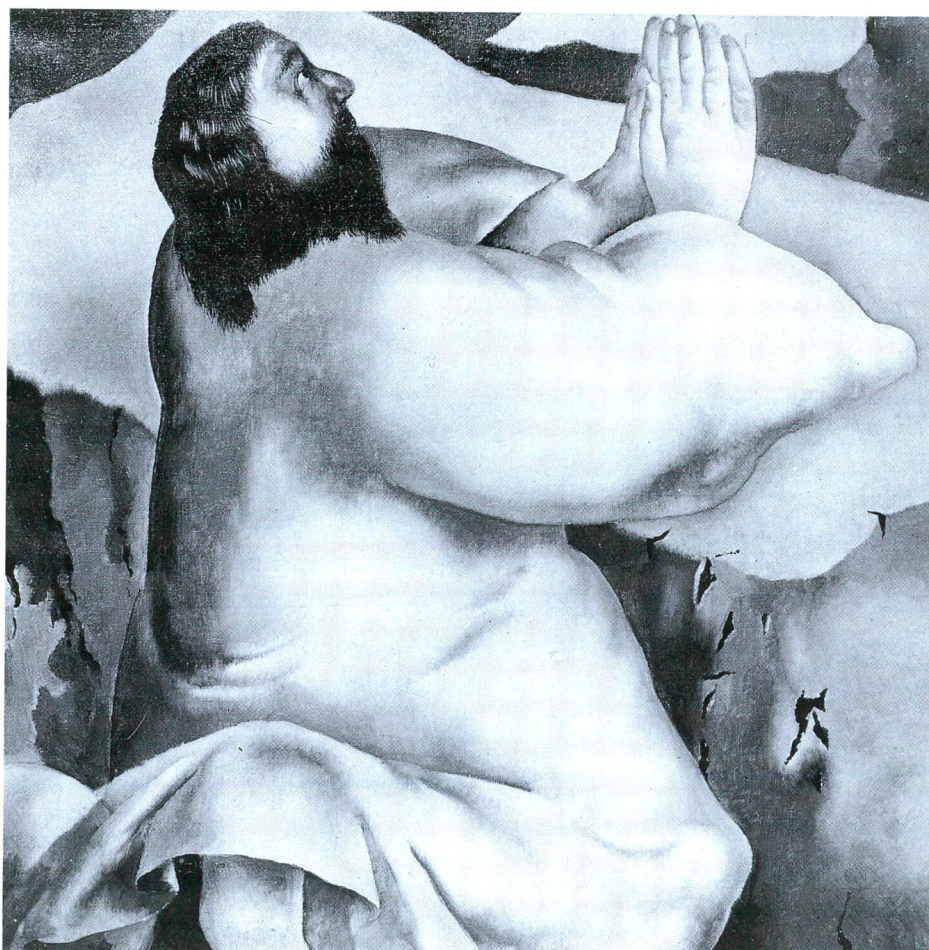
Breathe deeply the breath of life more abundant.

NOTES

1. As a youngster, I remember quietly standing at the foot of my great-grandfather's bed as he peacefully died, at home, encircled by his family. In the past several decades, dying and death have virtually disappeared from our homes and now occur in hospitals. I do not intend here either to indict or to exonerate what has become fact. I mention it simply to illustrate that many of us can now live an entire lifetime without having experienced someone's death. It *has* disappeared into a kind of invisibility.
2. Sittler's description of the "loss of identity and peril of loss of role" that lead an aging person to feel like "the residue of a ruin" (both sociologically and ontologically) lends confirmation to my diagnosis of our being out of "right relationship." The process of defining "who we are" by "what we do" in our modern Western culture plays into the circle of *doing* versus *being*, of absent living instead of presence. We become double victims, during our lives *and* during our aging.

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He Departed unto a Mountain to Pray. Painting by Stanley Spencer, 1939.

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Praying in Our Own Behalf

Toward the Revitalization of Petitionary Prayer

Donald Capps

A STUDENT CHAPLAIN WAS ASSIGNED to the urology floor of a large urban hospital. One of the patients, a white woman about 30 years old, had been hospitalized for two months and was described by the head nurse as depressed. It was likely, she thought, that this patient would continue to be hospitalized for some time. The student chaplain had visited her the previous week and observed that she was more interested in watching TV than in conversing with him.

This time, he found Mary a little more receptive. She told him that she was scheduled to have surgery again, because she had developed an infection from her previous surgery. This was nothing new, however: "I've had problems with infections for 11 years, but what can you do about it? It doesn't do any good to complain. I know that everyone is doing their best. I just have to be patient." The conversation shifted to the topic of Mary's family and their involvement with her. She volunteered that she had a cousin who was a Methodist minister and wrote her letters

and sent cards. This prompted the following exchange:

Chaplain: I imagine that you have people praying for you, then?

Mary: Oh, sure. My cousin prays for me, and my grandmother prays for me all the time. There are lots of people praying for me. My grandmother has even had the whole church pray for me.

Chaplain: You sound thankful for their prayers.

Mary: Sure.

Chaplain: Do you pray?

Mary: Sure. I believe in God. I don't really feel like I belong to any church. I don't go very often, but I believe in God, and I pray. I figure that if you just try to be a good person and do what's right, help other people, you know, that's what counts. I'm not real regular about prayer like my grandmother, but I pray.

Chaplain: When you pray, what kinds of things do you find yourself praying for?

Mary: Mostly for other people. You know, I mostly pray for other people instead of myself.

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Chaplain: You don't pray much for yourself?

Mary: No. I mostly pray for other people. I know that God didn't make me sick. I don't think God wants me stuck in the hospital. It's just my body. It's just the way things are. There are other people worse off than me, so I pray for them. If I'm meant to get better, I will, but there's nothing that I can do about it now except be patient. It isn't God's fault, though. I know that.

After a bit more conversation, the chaplain offered a prayer in which he asked God "to send your spirit of comfort and healing" to Mary. After the prayer, he expressed his hope that Mary would be feeling better soon, to which Mary replied, "Yeah, well, when it happens, it happens."

From his conversation with Mary about prayer, the chaplain felt that Mary had become apathetic about her life and her chances for survival. Her reluctance to pray for herself, her refusal to indict God for her condition, and her insistence that all one can do is be patient struck him as much too passive. Commenting on this visit, the chaplain said he felt "professionally frustrated" because he was "painfully aware that she did not respond to anything said in the prayer." He wanted to impart "a sense of empowerment and hope," but she did not seem willing or able to respond to his efforts to be what he called "a bearer of hope." He continued to visit her, but after a few weeks, she developed an abdominal infection and died, leaving him to wonder if her passivity, what she called her patience, had contributed to her death.

In his message at the memorial service at the hospital, attended by members of the family, the hospital staff, and other patients, he spoke about his own feelings of frustration over Mary's fatalistic attitude. The theme clearly struck a chord with the others present; several came up after the service to thank him for putting into words such an accurate account of their own feelings about her. In the chaplain's view, a key sign that Mary had a fatalistic attitude was her reluctance to pray for healing for

herself. Apparently, she did not think it would do any good to ask God for healing because God did not make her sick in the first place: "It's just my body. It's just the way things are." The chaplain apparently agreed that God did not make Mary sick, but he nonetheless felt that praying to God could make a difference. There was something he called God's "spirit of healing" that we could ask God to "send" to us. In Mary's case, this spirit of healing could counteract the infection slowly destroying her body.

This encounter raises the age-old question of whether it does any good to make requests of God. Mary seems to believe that asking God to do something about her illness won't make any difference. The chaplain believes it *will* make a difference. He believes that asking God to do something—"send your spirit of comfort and healing"—will encourage God to do just that. He also believes that in asking for God's help we mobilize our own resources against our illnesses.

Many of us are torn between Mary's view and the chaplain's view. Something in us resonates with Mary's realistic assessment of her situation and with her sense that there isn't much that God can do about it. God doesn't want her in the hospital, but God can't do much to get her out either. On the other hand, something in us also resonates with the chaplain's view that we should not hesitate to ask God to "send your spirit of comfort and healing," for there is, in fact, something that God can do about it, and God may even be waiting for us to ask before acting on our behalf.

I would like in this article to make a case for the chaplain's view while at the same time respecting Mary's viewpoint. The chaplain, I think, was too quick to dismiss her view as a "fatalistic attitude." But there is also something to be said for asking God to intervene in our lives and to do so in the very manner that we request. What is at stake here is the presumed efficacy of petitionary prayer.

Petitionary Prayer: Old and New Problems

Books and articles about prayer often identify different types of prayer. One of the best-known typologies is based on the acronym ACTS, which stands for prayers of adoration, confession, thanksgiving, and supplication. Prayers of supplication are then subdivided into prayers of intercession (prayers on behalf of others) and prayers of petition (prayers in one's own behalf). In saying that she tended to pray for others but not for herself, Mary revealed a preference for intercessory over petitionary prayer. In praying for Mary's healing, the student chaplain also engaged in intercessory prayer, although his comments after the visit suggest that he had some needs and desires of his own—for a greater sense of professional effectiveness—that he might well have voiced in petitionary prayers in his own behalf.

I want to focus on petitionary prayer for several reasons. First, more confusion surrounds petitionary prayer than any other type of prayer. Mary's worry that engaging in petitionary prayer might imply criticism of God, as though God was somehow responsible for the fact that she is stuck in the hospital, is one of many such confusions. Another reason for focusing on petitionary prayer is that Christians usually consider it the most basic form of prayer: this was the prayer form that Jesus himself used and taught his disciples to use. While expressions of adoration and thanksgiving occur in the Lord's Prayer, and while this prayer also contains a strong note of confession, the prayer itself is a prayer of petition. In both biblical versions (Matthew 6:9–13 and Luke 11:2–4), the prayer asks the "Father" (or "Our Father") to respond to certain urgent requests of the petitioner. Furthermore, Jesus' well-known prayer for personal deliverance in the Garden of Gethsemane (Matthew 26:39, 42; Mark 14:36; and Luke 22:42)—"remove this cup from me"—is also a petitionary prayer. A third reason for focusing on petitionary prayer is that much discussion of the

efficacy of prayer has centered on prayers for personal healing. The above case illustrates this in an especially poignant way. Would Mary be alive today if she had felt it appropriate to pray for her own healing?

If some hold petitionary prayer to be efficacious, and others hold it to be not efficacious, it is worth noting that those who are afflicted and those who work in health care can be found in both camps.

The Catholic sociologist Joseph H. Fichter (1981) asked health care personnel whether, in their experience, patients turn to God in their suffering. Most responded that it depends on the religious background of the individual. In general, those who turn to God when they are sick are usually also those who turned to God when they were healthy. Also, according to one of the nurses interviewed by Fichter, while people may pray for relief from pain, they are at least as likely to pray in response to the normal anticipatory fears and anxieties that accompany admission to the hospital (1981:59).

Concerning the health care professionals' own views regarding prayer, Fichter found that practically all were

believers in the existence and providence of God, but strength and intensity of this religious belief varies from person to person. . . . In general they have some faith in the power of prayer; most of them pray for God's guidance in their daily work, and they pray for their patients. We asked them the blunt question whether they think that "prayer is a helpful part of the healing process for people in pain." None of the respondents disagreed with this statement, but the percentage of those who "strongly agree" is twice as high among the religious Sisters (61 percent) as it is among the physicians (29 percent). (1981:90)

Recognizing that an affirmative answer to this question could simply represent a belief that prayer gives the patient a more positive attitude and not necessarily a belief that God actually *intervenes* in the healing process, Fichter asked whether "in the long run, all healing is attributable to the providence of

God.” He reports that this question “did not get a universal affirmation, even from the professional religious. Three quarters of the chaplains and Sisters agreed with the statement, as compared to three out of five (61 percent) of the physicians, nurses, and social workers” (1981:91). He suggests that the lower percentage among the latter group may be due to their desire to “reserve some of the curative achievement for themselves” (1981:91). Respondents may also want to reserve some of the credit for the patient, whose attitude may play an important role in the healing process.

When asked whether they had ever seen a case of “miraculous” remission (that is, one that was unexpected or unexplained by doctors), the majority (62 percent) said they were not aware of anything like this in their experience, while 26 percent claimed to have witnessed such a case and provided a description of it. More nurses than physicians and chaplains had seen an unexpected cure. Fichter suggests, however, that where doctors were previously more inclined to attribute such remission to a faulty diagnosis, they now offer this explanation less often, leaving greater room for the explanation that “the recovery of the sick person must be the direct intervention of God” (1981:93).

While Fichter’s study indicates that many health care professionals believe in the power of prayer to heal people and are also able to describe cases from their own experience that support belief in divine intervention, it does not tell us very much about petitionary prayer itself. It helps to explain why the student chaplain wanted Mary to pray for herself and why he felt it was appropriate to ask God to send his healing spirit. But besides informing us that belief in God’s involvement in the healing process is widespread, the study does not directly address the questions many of us have about petitionary prayer.

For example, we wonder whether we should ask God for healing (the chaplain’s view) or whether we should instead resign ourselves to whatever happens (Mary’s more “patient” approach). We wonder what an appropriate request of God is, and what is inap-

propriate, and further, what our attitude should be when we ask God for something. Should we be resigned, humble, and deferential (emphasizing our compliance with whatever proves to be “the will of God”), or should we be more bold, confident, and forceful (as in Jesus’ story of the widow who took her case to the judge on several occasions until, out of exasperation, he finally acceded to her request)? Moreover, how can we know whether our prayer has been answered, for couldn’t God answer our prayer in a way we did not expect or correctly perceive? Unless we take a completely unreflective, know-nothing approach to our religious faith, questions like these are unavoidable. Yet these questions and the difficulty we experience in getting any real answers often cause us to become skeptical about the whole business of petitionary prayer. No doubt, some of Mary’s lack of enthusiasm for what the chaplain was trying to do stemmed from such questions. And no doubt, she felt it would be impolite or tactless to raise them with the chaplain, especially when he seemed to be such a firm believer in the power of prayer.

Yet it is not only the laity who have these questions; the clergy—in their more private moments—often confess to having such difficulties with petitionary prayer. John Henry Newman, for example, acclaimed as one of the great religious thinkers of the nineteenth century, related the following personal experience: Throughout much of his adult life, he supported his widowed mother and his two unmarried sisters. When the burden had become almost more than he could handle, he prayed to God that he would find some new means to support his family, or that God would “remove the necessity” of his carrying the burden himself. In praying that God would “remove the necessity,” he was thinking about a letter he had recently received from his mother in which she reported that an aunt of hers had just died and had perhaps left her a substantial legacy. What happened instead, however, was that within a fortnight, Newman’s mother became ill and died. As he reflected with deep remorse on his prayer that the “necessity might be

removed,” Newman lamented, “Prayer is a two-edged sword.” This seems especially true of petitionary prayers, as prayers made in our own behalf can seem self-centered at best—and self-seeking and egoistic at worst. Is it any wonder that Mary is so reluctant to pray to God in her own behalf, in spite of the fact that she believes in God and prays for other people? And don’t we all question—even as we also admire—the student chaplain’s confidence in the efficacy of prayer?

These are just some of the weighty questions raised when we open the whole issue of petitionary prayer and its efficacy, especially in cases involving the very deep and very powerful desire we have for the healing of the human body. It would be presumptuous of me to claim that I have all the answers to these difficult questions. But I have struggled personally with these questions, and, out of these struggles, I have come to believe in the value of petitionary prayer even as I am very much aware that these challenging questions are not easily answered or resolved.

Compounding these age-old questions about petitionary prayer is the controversy today about the understanding of God that supported Jesus’ commitment to petitionary prayer. As the Lord’s Prayer and the Gethsemane prayer reveal, Jesus prayed to God as “Our Father” and “My Father” and thus forged a very strong link between petitionary prayer and a particular understanding or image of God. When God is viewed as a father, it seems especially appropriate to view prayer as an act of petition, for it is common for sons and daughters to ask their fathers to take certain actions in their behalf.

Recent studies of Americans’ images of God tell us, however, that only 68 percent of Protestants, 60 percent of Catholics, and 15 percent of Jews are “extremely likely” (as opposed to “somewhat likely”

or “not likely at all”) to think of God as a father (Roof and Roof 1984). Does this mean that belief in the value of petitionary prayer is likely to decrease because there is decreasing perception of God as a father? This is one conclusion we might draw from these statistics. On the other hand, another study of Americans’ images of God shows that the image of

God as father is strongly and positively associated with the image of God as healer (Nelsen, Cheek, and Au 1985). Thus when Christians call on God for healing, they are likely to be thinking of God as father, quite likely as the very father on whom Jesus himself called in the Garden of Gethsemane. Still, where earlier generations of Christians could assume a common understanding of the God whom

they addressed in their petitionary prayers, this is much less true today. Whether one’s requests are addressed to God as father, mother, healer, liberator, judge, creator, or friend is likely to bear on the degree of confidence one has that God hears one’s prayer, and on one’s expectations about how God might answer.

Furthermore, does petitionary prayer demand that the petitioner view God as a person, or could one just as well invoke the propensity of the natural or material world—including various organs in our own bodies (for example, the liver)—to regenerate itself? In his major treatise on the history and psychology of prayer, Friedrich Heiler (1932) points to three elements of the prayer experience: faith in a living personal God; faith in his real, immediate presence; and a realistic fellowship that we enter into with a God conceived as present. Heiler goes on to note that, of course, this living personal God is not a human being but a “superhuman Being on whom he feels himself dependent, yet a being who plainly wears the features of a human personality, with

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thought, will, feeling, self-consciousness.” He concludes that “belief in the personality of God is the necessary presupposition, the fundamental condition of all prayer” (1932:356). For Heiler, petitionary prayer is inconceivable if God is not understood to be a person.

However, in a very provocative essay published shortly before his death, Paul W. Pruyser, a clinical psychologist who is well-known among pastors and chaplains for his book *The Minister as Diagnostician* (1976), comments on a phenomenon he has noticed among some of his aging friends—that “they no longer feel impelled to pay homage to a quasi-human God in worship and prayer” (1987:178–79). This is not, he says, a “conflict-ridden, strident, or bellicose” rejection of a personal God; nor does the person necessarily disown a “previous more traditional religiousness.” In fact, “the person may now have a benign, slightly bemused attitude toward fantasies and feelings, ritual acts, and various obligations in which he or she used to engage with the same sincerity that typifies the present abstinence from such observances” (Pruyser 1987:179). If this were only the experience of some of Pruyser’s aging friends, we might be inclined to view it as an interesting phenomenon, nothing more. But Pruyser goes on to say that

something like this process has slowly and steadily been happening to me and from impressionistic observations of old people in hospitals, nursing homes and hospices and from conversations with their attending caretakers, including chaplains, one learns that there appears to be a bi-polar distribution of religiousness in the aged and dying: some becoming more intensely or articulately religious than they were before, and others becoming less involved than they were. Moreover, despite the adage that there are no unbelievers in fox holes, I have long been impressed by the frequent absence of any religious allusions, imagery, or feelings in many people’s self-accounts of traumatic situations, their dreams around important events, and their responses to life-crises—even in those persons who have

a denominational affiliation, know religious language, and have had religious training—people whom one would expect to experience such events religiously. (1987:179)

Pruyser wonders what one is to make of these impressions. Do some people “outgrow” religion after having embraced it? Is there a developmental dynamic in religion itself that moves from personal views of God to impersonal or even nontheistic conceptions? Or perhaps, he suggests, the process is more dialectical, as persons for whom God is a very personal being early in their lives become “emancipated” in later life, while others who did not view God as a personal being in early life experience God as very personal in their later years.

These questions have important bearing on petitionary prayer, especially for Christians, whose models for petitionary prayer are the prayers of Jesus. Not only are Jesus’ prayers addressed to a personal God (as father), but they reflect a very particular understanding of this personal God. Biblical scholars, following the ground-breaking work of Joachim Jeremias (1971), now generally agree that Jesus was unique among Jewish religious teachers and prophets not only in speaking of God exclusively as father but also in using a very informal, colloquial Aramaic word for father—*abba*—roughly equivalent to the English word *daddy* or German word *papa*. (This English equivalent may, however, be somewhat misleading, as both adults and children addressed their fathers as *abba* in Jesus’ time.) As Jeremias points out, “The use of the everyday word ‘abba’ as a form of address to God is the most important linguistic innovation on the part of Jesus” (1971:36). Not only is it most unusual that Jesus “should have addressed God as ‘my father’; it is even more so that he should have used the Aramaic form ‘Abba,’” as *abba* was a most intimate form of address. Also, “the complete novelty and uniqueness of ‘Abba’ as an address to God in the prayers of Jesus shows that it expresses the heart of Jesus’ relationship to God” (Jeremias 1971:64–67).

The personal, even intimate form of address in Jesus' model prayers confirms Heiler's point that prayer not only assumes a personal God but also assumes a personal relationship between self and God:

Prayer is . . . a living relation of man to God, a direct and inner contact, a refuge, a mutual intercourse, a conversation, spiritual commerce, an association, a fellowship, a communion, a converse, a one-ness, a union of an "I" and a "Thou." Only an accumulation of these synonyms which human speech employs to make clear the innermost relations of man to man, can give an appropriate picture of the realistic power and vitality of that relation into which the praying man enters with God. (Heiler 1932:357)

For Christians, Jesus' own petitionary prayers create a very strong expectation that our prayers to God in our own behalf will reflect this intimate, personal relationship between self and God. Perhaps many of us do experience precisely this relationship as we pray for personal healing or for some other need or desire. Yet others of us, perhaps the great majority, do not. Our prayers feel perfunctory, embarrassing, or artificial. We have little sense of an "I" communicating with a "Thou," little apprehension of "a direct and inner contact," of one heart speaking to another. For every one who experiences prayer as a direct personal conversation with God, there are undoubtedly two others who view it as an empty form. There are a number of ways to explain why a prayer form, meant to be so personal and intimate, is for many of us the exact opposite. I would like to take special notice of one such explanation, one that concerns the original models—Jesus' own prayers—which have had such a strong, enduring influence on Christians' petitionary prayers ever since. In doing so, I set the stage for what I consider to be a better way of understanding Jesus' prayers and thus a better understanding of the efficacy of petitionary prayer in our own times.

Deference to the Will of God

ONE REASON PETITIONARY PRAYER HAS FALLEN into disuse by many who consider themselves to be believers in God is that petitionary prayer is often understood as an attempt to influence the "will" of God. I believe that this understanding of petitionary prayer stands in direct opposition to the understanding that Jesus intended, namely, that it be an intimate, personal conversation, one in which both persons communicate fully and freely what is on their minds and what their innermost hearts have prompted them to say. I suggest that one feature of Jesus' model prayers stands in tension with their personal communication aspect. This is his emphasis in both prayers—the Lord's Prayer and the Gethsemane prayer—on the "will" of the Father. Matthew's version of the Lord's Prayer includes this petition: "Thy will be done on earth as it is in heaven." And in all three Gospel versions of the Gethsemane prayer, Jesus made this statement of apparent deference to his father after he requested the removal of the cup: "Yet not what I will, but what thou wilt," or "Nevertheless not my will, but thine, be done."

In my judgment, Jesus' emphasis on the will of God in the Lord's Prayer, and his very strong emphasis on the conflict of his will with his father's in the Gethsemane prayer, is responsible for much of the confusion that has surrounded petitionary prayer throughout the centuries. Moreover, it continues to sow confusion for us today, diminishing our ability to view petitionary prayer as a wonderful opportunity to talk intimately—in heart-to-heart communion—with God. The problem, however, does not lie primarily with the model prayers themselves but rather with the fact that these prayers, especially the Gethsemane prayer, are taken out of context. And whenever we take biblical material out of context, we end up misrepresenting what the biblical material says or means. This is precisely what has



Ask, Seek, Knock. Etching by Joan Bohlig, 1988.

happened with Jesus' prayers, with the result that we are either so confused or turned off by petitionary prayer that many of us—like the patient Mary, above—have decided it is better not to ask God for anything at all.

I have said that Jesus' statements of deference to the will of God in the Gethsemane prayer stand in some tension with the expectation that prayer to God is a very personal conversation. I can best explain this by reference to human relationships, especially those between children and parents. If, as Heiler suggests, the main features of a human personality are thought, will, feeling, and self-consciousness, it is the will that is usually the source of greatest tension and conflict between children and parents. In fact, many so-called Christian psychologists believe that the primary obligation of Christian parents is to "break" the child's natural will so that the child will be receptive to the will of God. They enjoin parents to punish their children, often very severely, and to do so when the child is very young (as early as eight months old). As one of these self-proclaimed Christian psychologists, J. Richard Fugate, author of *What the Bible Says about Child Training*, puts it, "The only issue in rebellion is will; in other words, who is going to rule—the parent or the child. The major objective of chastisement is forcing the child's obedience to the will of his parents" (1980:137). Or, as Jack Hyles, author of *How to Rear Children*, writes,

The spanking should be administered firmly. It should be painful and it should last until the child's will is broken. It should last until the child is crying, not tears of anger but tears of a broken will. As long as he is stiff, grits his teeth, holds on to his own will, the spanking should continue. (1972:99–100)

While, to many of us, these authors' position on the necessity of breaking the child's will may seem extreme, even un-Christian, the idea that our "natural" will is in conflict with or is rebelling against the will of God is a well-established belief

among Christians. As Susanna Wesley, the mother of John and Charles Wesley, wrote in 1732,

religion is nothing else than doing the will of God and not our own. . . . The one grand impediment to our temporal and eternal happiness being this self-will, no indulgence of it can be trivial, no denial unprofitable. Heaven or hell depends on this alone; so that the parent who studies to subdue it in his child works together with God in the renewing and saving of a soul. (Greven 1990:62)

Susanna Wesley's language may be somewhat dated, but many Christians will agree with her that an inherent conflict exists between our self-will and the will of God and that it is the task of Christian parents to either "break" or "bend" the child's will so that the child will be set on the path of conformity to the will of God.

I believe that Mary's reluctance to ask God for healing is due, in part, to her reluctance to assert her own will. Her will has been "tamed" and even perhaps "broken." While she feels that it is not God's will that she be stuck in the hospital, and therefore the situation is not exactly a conflict of wills between herself and God, there is, nonetheless, a reluctance on her part to assert her will in the matter. It is as though she believes that it is her duty, as a good, obedient child, not to affirm her "natural" will (in this case, the will to be healed) but simply to accept whatever happens.

There is, however, a very interesting irony in this program of breaking the child's will: This is the very strong evidence we have from adults' accounts of the physical and emotional punishments they sustained as children that the fear of being punished caused them to engage in petitionary prayer. The evangelist Aimee Semple McPherson tells how she, as a young girl, would be banished to her room to await her spanking:

On one such occasion I stood looking wildly about for a way out of the dilemma. No earthly recourse was nigh. Taught as I was about

heavenly intervention, I thought of prayer. Dropping to my knees on the side of my bed, I began to pray, loudly, earnestly, "Oh, God, don't let mama whip me! Oh, God, dear, kind, sweet God, don't let mama spank me!" (1979:13)

Saint Augustine also turned to petitionary prayer when he was being beaten by his teachers for being "slow at learning," and his parents merely laughed when he showed them the stripes on his back. As he wrote in his *Confessions* about this experience, "I, little one, but with no little feeling, I prayed to you that I would not be beaten at school [but] you did not hear me" (1960:52). Instead of viewing their parents as the legitimate agents of God's discipline, these children saw God as a potential savior and called on him in their distress. In both cases, God did not intervene, and the punishments continued. The irony here is that the children are being punished because their actions are viewed by adults as self-willed and therefore contrary to the will of God, while the children are calling upon the very God whose will they are said to be flouting, and doing so because they have been assured that God intervenes to help persons who have no other recourse.

I believe that Jesus' model prayers, especially the Gethsemane prayer, loom in the background of these punishment scenarios, as they both envision a conflict between the will of God and our own and counsel the subordination of our will to God's. The Gethsemane prayer also leaves the distinct impression that God, in his fatherly wisdom, will not always intervene but will instead allow the petitioner to experience the fate from which he or she pleads to be spared. What is especially striking about the punishment scenarios involving small children, however, is how little verbal communication occurs between the parents and the child, as the parents rely almost entirely on the stick or the hand to "speak" for them. Thus an inverse relationship exists between the conflict of wills and intimate conversation between parent and child. If such con-

versation does occur, it happens only after the child's will has been broken, and the child is now considered able to hear what the parent has to say. Only then can the parent get across to the child that the parent truly loves the child, and only then can the child profess love for the parent in return. In effect, will and intimacy are in deep tension with one another and ultimately irreconcilable.

This is not, however, the case with Jesus' prayer in the garden of Gethsemane. This prayer is profoundly intimate: it begins with a very personal address—"My father"—and proceeds with an unabashed and unflinching statement of personal desire: "Remove this cup from me." Moreover, the ensuing statement, "Yet not my will but thine be done," is expressed voluntarily and is not, as in the examples just cited, imposed from without by an external authority. Also, it is especially striking that even after Jesus said to his father, "Yet not my will but thine be done," he *continued to pray* that the cup might be removed. As Luke expresses it, "And being in an agony he prayed more earnestly" (22:44). Thus, although Jesus offered to defer to his father's will, he did not cease to pray for what he desired. If anything, it meant that he was free to pray even more earnestly, precisely because he had placed the final disposition of the matter in his father's hands.

Based on this analysis of the Gospel texts, we need to reject the traditional interpretations of Jesus' Gethsemane prayer, such as this one offered by John Casteel in his book *Rediscovering Prayer*:

Only the endorsement of our asking with the words Jesus used in Gethsemane—"Nevertheless, not my will, but thine, be done"—can save our prayers from becoming self-centered, trivial, or even harmful to ourselves or others. But to pray in this way is not easy. As William Temple said, we are tempted to pray that God's will be done, but then go on to tell God what his will should be. (1955:115–16)

This view exaggerates the conflict or discrepancy between our will and God's. Moreover, it is overly suspicious and censorious regarding the motivations

behind our petitionary prayers (for how can prayers in one's own behalf not be *self*-centered?). Furthermore, it fails to take adequate account of the fact that Jesus' prayer at Gethsemane is part of an ongoing conversation or dialogue with his father, which is why he is able to discern his father's will in the matter and, at the same time, is free to "tell" God what he deeply and urgently wishes.

By reducing Jesus' statement—"Yet not my will but thine be done"—to a formulaic statement recited in every one of our petitionary prayers, we lose all sense of its original expression of personal love and solidarity. Absent from our prayers are the intimacy with which Jesus speaks to his father and the expression of any real desire or passion. The experience becomes desultory and routine. We pray in a spirit of resignation, as we assume that our will is contrary to God's and that, in any event, nothing we might say to God could possibly alter God's will. And even if it could, we doubt that this would be desirable, for, as Susanna Wesley put it, "Religion is nothing else than doing the will of God and not our own" (Greven 1990:62).

If we assume that our will and God's will are inherently incompatible, the prospect of our will actually prevailing will not bring us any real satisfaction. Rather, this is the outcome we most fear and dread: we cannot help believing that in one way or another we will pay a price for our seeming victory over the will of God. If we get our way, it is as though God has decided to teach us a lesson: "OK, have it your way, but I guarantee you that you will be sorry." Is it any wonder, then, that Mary not only chooses *not* to pray for her recovery but also responds to the student chaplain's hopes for her recovery with the words, "If it happens, it happens"? She dares not speak to God about her desire to be well again. If she

did, God might take it as an act of rebellion, an implicit criticism. This is all too reminiscent of the standoff between child and parent, where the child knows the safest strategy is to keep her thoughts to herself, lest she incur her parent's further displeasure.

Some might object to this whole line of argument because it seems to imply that conflicts between our will and God's will simply do not exist. However, although our experiences of punishment as children cause many of us to exaggerate the conflict between God's will and our own, such conflicts do exist. The Gethsemane prayer itself presents a powerful, if disturbing and ultimately impenetrable, example of how the human and

divine will may be at times in fundamental conflict. Virtually every book I have read on prayer has a chapter entitled "Unanswered Prayer," and the key issue addressed therein is the discrepancy between God's will and our own. In his inspiring book *The Meaning of Prayer*, the great American preacher Harry Emerson Fosdick suggests that it is sometimes for the best that our will is superseded by God's will, either because God knows better than we do what is good for us or because God actually wills better things for us than we will for ourselves (1949:111).

Still, we tend to exaggerate the conflict between God's will and our own. We do not give enough credence to the possibility that God is not primarily trying to thwart our will or to correct it but actually shares our desires and wants for us what we want. Furthermore, we do not give sufficient attention to the resources available to us that, over time, effect a real, not imagined or merely wishful, congruence between what we want and what God wills for us.

**Coorientation does not mean
that the two persons in the
relationship must always see
things eye-to-eye.
If they did, neither would be
independent of the other;
the "I" and the "Thou" would
be completely fused.**

The Convergence of Wills

The religious community can play a vital role in construing, in advance, what may or may not be the will of God. As D. Z. Phillips points out in *The Concept of Prayer*, religious communities or traditions help the individual believer to understand or interpret the will of God in a particular situation:

Although there are cases where no one but the person involved can say whether a certain course of action is the will of God or not, there are also *limiting* cases which enable one to say, "This *could* be the will of God," or "This *could not* be the will of God." If this were not the case, an individual's claims about answers to prayers and directions from God would be beyond contradiction. The believer could say, "This is what God has told me, who are you to argue?" Despite the enormous diversity of problems and questions which men bring to God in their prayers, the answer God is said to give cannot be *anything* an individual chooses to mention, since in order to be understood as God's answer, it must be compatible with the *known* will of God, that is, with the general nature of God as found in Christian traditions. (1981:151–52)

To illustrate his point, Phillips cites the example of God telling Abraham to sacrifice his son Isaac. If someone living today were to argue, on the strength of the Abraham-Isaac story, that it is God's will that he sacrifice *his* son, the only appropriate response is that this cannot be. Why? Because "What Abraham did can only be understood, if understood at all today, by reference to the community of his day, the religious nature of the family, Abraham's position in the tribe, and, of course, the practice of child sacrifice itself. These factors are not incidental to the action, but give it its meaning" (1981:152–53). Thus, Phillips concludes, "What can conceivably be said to be the will of God is determined by prevailing beliefs about God" (1981:153). And this means that in a general sense, God's will is already known. To pray to know God's will, then, is somewhat paradoxical.

One cannot pray to know God's will unless God's will is already known. I do not mean that one cannot seek God's guidance on a problem unless one knows what God's guidance is going to be, since that would make prayer superfluous. By "already known" I refer to the communal concepts of God which determine the broad limits of what the will of God could and could not be, in sympathetic or unsympathetic relation to which the individual believer prays to know the will of God. (Phillips 1981:157)

Thus if the majority of Christians can readily think of God as healer, they would assume that God's will would be for Mary to get better and eventually be restored to full health. This, in fact, is what the student chaplain assumes when he prays that God's spirit of healing will come to Mary, an assumption that many who attended the memorial service—family members, health care professionals, and patients—confirmed when they thanked him after the service for his remarks.

This, then, is a concrete example of how the religious community plays a vital role in construing, in advance, what may or may not be the will of God. Of course, the religious community does not speak with a unified voice—some religious groups have actually claimed that AIDS is God's revenge against homosexuality—but it does mean that religious communities play a vital role in "determining the broad limits of what the will of God could and could not be" (Phillips 1981:157). And Mary, while she disclaims personal association in the religious community, shares this view of what God's will could or could not be when she says that God is not to blame for her condition. Perhaps the difference between Mary and the student chaplain is not in what they construe to be the will of God but in their views concerning the propriety of asking for a manifestation of God's will. Mary may worry that God would construe this as a criticism, while the student chaplain believes that it communicates one's confidence in God.

But the religious community is not the only resource available for engendering congruence

rather than conflict between our will and God's. An equally important resource is the individual's own relationship with God. When Jesus prays in the Garden of Gethsemane, his personal relationship to God seems to count much more than the religious community in "determining the broad limits of what the will of God could and could not be." We know from the Gospel accounts of his long-standing relationship with God as his personal father. In relating the story about the 12-year-old Jesus in Jerusalem and his distraught mother who found him in conversation with the learned teachers, Luke suggests that Jesus' relationship to God as his personal father can be traced to his early childhood: "Did you not know that I must be in my Father's house?" (2:49). Because it was a long-standing relationship, and apparently much more intimate than his relationship with his adoptive father, Joseph, Jesus "knew" his father's (God's) will without needing to be told what it was. In effect, he had internalized the major features of his father's personality—his thoughts, feelings, will, and self-consciousness—and was able therefore to "sense" or "intuit" his responses.

A concept in communication theory called *coorientation* (Newcomb 1953; Johnson 1977:70) helps us see how our relationship with God may determine, in any given situation, what we might call the "narrower limits" of what the will of God could or could not be (in contrast to the "broad limits" provided by the religious community). In communication between individuals, coorientation means that we simultaneously orient ourselves to the *subject* of discussion and to another person's anticipated *view* of the subject. As we get to know another person, we come to have a sense of what she thinks or how she feels about a given subject; this preknowledge leads us either to bring up the subject often (as it evokes in the other a sense of delight) or to rarely broach it (as it evokes pain or provokes anger). Coorientation may occur without any verbal exchange, as we may simply *anticipate* the other person's response to the subject in question, and this anticipation takes the place of an actual verbal

response: "There's no need to ask my mother if I can go. I already know that she will say no." Or, alternatively, "There's no need to ask her. I already know that she will say yes."

When applied to petitionary prayer, the concept of coorientation suggests that we may anticipate God's response to a need or problem of ours, with such anticipation based on how we have experienced God in the past. The petitioner "senses" or even "knows" how God views the matter, and this knowledge or awareness is itself a response to one's prayer. This anticipation of God's response may occur even when our view and God's view are not entirely the same. As George Kelly points out, to say that we "effectively construe the other person's outlook . . . is different from saying that each must understand things in the same way as the other" (Johnson 1977:70). We may urge God to respond in such-and-such a way to a need or desire of ours and simultaneously doubt whether God will. Coorientation does not mean that the two persons in the relationship must always see things eye-to-eye. If they did, neither would be independent of the other; the "I" and the "Thou" would be completely fused. On the other hand, coorientation *does* mean that each person assumes the perspective or point of view of the other, as the very point of coorientation is that we know not only our own thoughts and feelings about the matter in question but also the thoughts and feelings of the other. Sometimes, in fact, we will say to the other, "I don't think you really mean what you have just said. I know you too well."

Thus in petitionary prayer, we assume that, even as we view the matter from what we understand to be God's perspective, so God views it from ours. Our will, in the end, may or may not prevail. But whether it does or not, we feel we have been understood, meaning that God has entered as thoughtfully and feelingly into our perspective as we have entered into God's. In fact, as it is God's nature to be understanding, we may assume that God's ability to enter into our perspective is far more profound and far more fully developed than our ability to enter into God's. Thus we may make a useful distinction be-

tween *answers* to prayer (which involve God's direct intervention in our situation) and *response* to prayer (which involves understanding the situation from our perspective).

We can say, on the basis of how coorientation works between two human individuals who have each other's interests at heart, that God always responds to our prayers, as it is God's nature to do so. What we may not know is how God will intervene in the matter, though, even here, our prior experience of God's intervention in our lives provides some insight and clues. This is why we must view petitionary prayer in the context of our personal relationship to God; this relationship plays at least as important a role as the religious community in determining what the will of

God could be in any given situation. As I have suggested, the religious community establishes the "broader limits" in determining what God's will could be in a given situation, while our personal relationship to God sets the "narrower limits"—because what could well be within the broader limits of God's will for Christians in general may not be the will of God for you or for me in this particular instance. Christians understand God to be a healer (that is, healing is integral to God's nature), and they reject the idea that God might be a destroyer. Yet Jesus' Gethsemane prayer, as well as the testimony of all the Christian martyrs since, indicates that for particular individuals in particular circumstances, other features of God's nature—for example, God's commitment to justice—may take precedence over the nature of God proactively to heal and sustain our lives.

If offering petitionary prayers allows us to view certain matters from God's perspective, our prayers will inevitably influence our own personalities, espe-

cially in effecting a greater congruity between our own natural wills and what we understand God's will to be. As philosopher William James points out in *The Varieties of Religious Experience*, it is "not that particular events are tempered more towardly to us by a superintending providence, as a reward for our reliance, but that by cultivating the continuous

sense of our connection with the power that made things as they are, we are tempered more towardly for their reception" (1958:359). This does not mean that we must abandon our own will and become passive or merely resigned, for this would mean giving up our own personality, our own individuality, with our own thoughts, feelings, will, and self-consciousness—and this is the very opposite of what God wills. Is it not,

after all, God's nature both to value and to foster our becoming the selves that we truly are? Instead, this tempering means that our personalities bear the influence of our relationship to God and reflect a whole lifetime of viewing our situation from what we understand to be God's own perspective.

We know, of course, that we have often misjudged God's perspective—often because we have held false or distorted images of God. But this is precisely the value of engaging in petitionary prayer: Prayers in our own behalf allow us to reflect on our intuitions regarding God's view of our situation. Such reflections may cause us to reevaluate what we previously viewed as the limits of what God's will for us could or could not be.

One unexpected and perhaps paradoxical consequence of this movement toward greater congruity between our will and God's is that over the period of a lifetime we may actually find ourselves engaging less and less in the act of petitionary prayer, at least as a formal ritual. As the prayers of Aimee Semple

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McPherson and Saint Augustine illustrate, our earliest experiences of petitionary prayer tended to reinforce our perception that our will and God's conflict with one another. But if, over the course of time, the taking of God's perspective means that our will and God's will become more and more congruent—increasingly indistinguishable from one another—then we may not engage as much as we previously did in petitionary prayer; such prayers may seem increasingly superfluous. And this may be the way to read Paul Pruyser's observation that he and many of his aging friends are not as invested in prayer as they used to be. Perhaps, as he suggests, they have lost interest in God, but perhaps, instead, their lifelong habit of viewing their lives from God's perspective as well as from their own has narrowed the gap between these two perspectives to such a degree that they are nearly indistinguishable. When this occurs, "petitioning" God for this or that rings false. And, where some difference continues to exist, we may view it with greater equanimity, not unlike the real differences between spouses that in the course of time are no longer sources of frustration and anger but matters of amusement and easy tolerance.

In any event, when we apply the concept of coorientation to petitionary prayer, we can appreciate the fact that prayer leads to increased understanding, both of God and of ourselves. By viewing the matter from God's point of view, we gain a new perspective on our own point of view. We are, for example, able to be more critical of our own view. This is why various authors, writing about the positive effects of prayer, suggest that one of its most important benefits is its contribution to our self-knowledge. As Daniel Day Williams points out, one way we keep prayer from becoming a mere routine and instead insure that it retains real meaning is "to keep it close to the search for self-knowledge" (1961:116). Or, as Ann and Barry Ulanov assert, "To pray is to listen to and hear this self who is speaking," and one way in which we "hear" and come to know our deeper selves is by hearing ourselves express our deepest desires (1982:1, 14). Unlike our *needs*, which

concern what is necessary for us to get through life, our *desires* express what we believe we need to become the self we truly are, to live the life we were created for. In hearing ourselves express these desires and intuiting how God hears these expressions of desire, we increase in self-knowledge.

Taking the Role of the Psalmist

BY STRESSING THAT WE COME TO KNOW the will of God in two important ways—through religious communities and through our own personal relationship to God—I may have created the impression that these two resources are mutually exclusive. As I do not believe that they are, I want to conclude by drawing attention to another way in which we can apply the idea of coorientation to petitionary prayer: We can determine the limits of what God's will could be in a given instance by allowing the experience of others to guide us. In effect, we take someone else's perspective as our own. For many of us, the perspective we adopt is that of someone we know or knew personally, such as a parent, a grandparent, a revered pastor, or an inspiring teacher—a person whose own sense of God's will profoundly influences our perceptions of what God wills in the situations we now confront. If we experience defeat, the memory of a grandmother who taught us that God never wants us to give up sustains our renewed efforts. Or a beloved church-school teacher's conviction that God despises bigotry in every form enables us to believe in our hearts that it is God's will that we accept our son's or daughter's homosexual relationship.

But we can also adopt the perspective of another by identifying with a character in the Bible or an important saint or other exemplary figure in our religious tradition. Those of us who value the Bible as our most sacred text often take the perspective of the psalmists and allow the petitionary prayers in the Psalms both to put our own desires into words and to shape our understanding of what God could

and could not will for us in the situation we now confront. The Psalms have been particularly popular where the situation involves the physical or emotional health of the petitioner, because so many of the Psalms address precisely such situations. Thus the petitioner allows the psalmist to speak for her and anticipates that God will respond as God responded to the psalmist.

One of the most powerful testimonies to this form of coorientation is Martin E. Marty's *Cry of Absence* (1983), written for those who are going through "the winter of the heart," when bleakness grips the soul and even God seems absent. Noting that many Christians in this situation have not found helpful the methods of "pure meditation" or "unsupported prayer" advocated by the great Christian mystics (1983:22), Marty recommends a more mediated approach based on reflection on texts, especially biblical texts, and argues that this approach should never be considered second-rate:

Through texts one can make friends across miles and years. They make possible the stimulation of imagination to picture what it would have been to be someone else, somewhere else, at a different time. In the process, therefore, they allow for an enlargement of personal horizons, an overlapping of my frontiers with those of another in the spirit. One's own soul may be impoverished and thin on resources. The chances are strong that this is so in an epoch of homelessness for the spirit. . . . Through the text, one can at least for part of the way "hitchhike" on the spiritual experience of another—perhaps a spiritual genius, certainly one more religiously musical than a wintry sort would be. Through access by means of the text, one can "barnacle" oneself to the word of another. One can be a "parasite" that lives off another spiritual organism. These words are not all lovely, not all positive sounding. But the hitchhiker does, or can, "get there." The barnacle enjoys movement, the parasite knows life. More positively: both may be in range of something greater than what they would have known had they stayed home or unattached. (1983:27)

The text Marty chooses for himself is the Book of Psalms, because the Psalms, being found in the Bible, stand at the "root" of our religious tradition (1983:33), and also because more than half the Psalms have "as their major burden or context life on the wintry landscape of the heart" (1983:39).

Marty's project is an example of the form of coorientation known as biblical role taking. As the Swedish psychologist of religion Hjalmar Sundén describes this phenomenon (1959), individuals, especially when in crises or difficulties that threaten to overwhelm them, will identify with a biblical character (for example, David, Mary, Jesus) or biblical author (for example, a psalmist or the author of Ecclesiastes) confronted with a similar crisis or difficulty. When we view our own situation within the frame provided by the biblical story, we do not feel so utterly alone but instead experience the support and encouragement of the biblical figure. Also, and more important, this role taking of the biblical figure enables us to ascribe a role in our lives to God as well, as we anticipate that God will respond to us in our situation as God responded to the biblical figure.

Sundén (1987) points out that one of the most popular sources of biblical role takings through the centuries has been the Psalms. This is partly because they are written in the first-person singular, but it is also because they are unusually self-disclosive: the psalmist is not afraid to reveal his true feelings—including feelings of hatred and desires for revenge against those who have caused him hurt and pain—and he is not at all reluctant to make strong and explicit requests of God in a very forthright manner. What this means, in effect, is that our most popular biblical role takings are those in which the biblical figure—the psalmist—is involved in petitionary prayer. As Marty puts it, we "hitchhike" on the expressiveness of the psalmist, relying on him or her to articulate our needs and desires and to convey our hopes and aspirations to God. Much like a sympathy card that expresses our feelings better than we could express them ourselves, the psalmist speaks for us. But more than this, the psalmist assists us in placing



The Trinity. Fresco (detail), National Preparatory School, Mexico City, by J. C. Orozco, 1923.

ourselves in the very presence of God, for we experience the psalmist's invocation of God deep in our own hearts, as our very own. We pray the text.

The fact that so many of the Psalms are petitionary prayers means that they can be of particular value to persons, like Mary, who for one reason or another are unable to pray to God in their own behalf. Had the student chaplain encouraged her to read a portion of a psalm, or listen to him as he read it on her behalf, he might thereby have created the context for a biblical role taking, with Mary identifying with the psalmist and adopting the psalmist's anticipation of response from God as her own. A psalm that would affirm her belief that she must be patient, but would reframe this belief as a prayer—and thus as anticipation of response from God—is Psalm 40, especially the first three verses.

I waited patiently for the Lord;
he inclined to me and heard my cry.
He drew me up from the desolate pit,
out of the miry bog,
and set my feet upon a rock,
making my steps secure.
He put a new song in my mouth,
a song of praise to our God.

These verses from Psalm 40 might be followed with verses 14–17 of Psalm 103, which affirm Mary's view that God doesn't want her to be stuck in the hospital, that "it's just my body . . . just the way things are":

For he knows our frame;
he remembers that we are dust.
As for man, his days are like grass;
he flourishes like a flower of the field;
for the wind passes over it, and it is gone,

and its place knows it no more.
But the steadfast love of the Lord
is from everlasting to everlasting.

He might then conclude the readings with Psalm 131:

O Lord, my heart is not lifted up,
my eyes are not raised too high;
I do not occupy myself with things
too great and too marvelous for me.
But I have calmed and quieted my soul,
like a child quieted at its mother's breast;
like a child that is quieted is my soul.
[I will] hope in the Lord
from this time forth and for evermore.

These readings would affirm the value that she places on patience and acceptance of a situation that she has no power to change, but they would also introduce the countervailing theme that the chaplain wishes to impart—"a sense of empowerment and hope." Psalm 131 is especially important in this regard because it is sensitive to Mary's mood—she does not want to get caught up in false optimism, to entertain thoughts of being healed only to be let down—but at the same time it suggests that her "patience" involves more than resignation, that whatever the vicissitudes of her illness, she can live in a quiet, undramatic but firm and constant hopefulness. This is undoubtedly a more subtle form of "empowerment" than the student chaplain envisions, but it is no less real. The reading describes the empowerment a child feels when leaning against her mother's breast, perhaps feeling the rhythmic beating of her mother's heart, and sensing in the calm of that moment that, whatever happens to her, whatever her final fate, all will be well. The hope that the psalmist represents is not based, finally, on the anticipation of physical healing but on the assurance that God's steadfast love is from everlasting to everlasting.

In one of the most easily overlooked passages in Luke's account of Jesus in Gethsemane, we are told that after Jesus prayed that not his will but his

father's be done, "there appeared to him an angel from heaven, strengthening him" (22:43). We *could* view the angel's appearance as a hallucinatory experience or perhaps as a nice bit of outdated religious piety. But I believe that the angel from heaven represents God's response to Jesus' voluntary renunciation of his own will. God did not intervene to change the course of events. But God did respond to Jesus' prayer by sending an angel of mercy. So let us pray that when we, like Jesus, come to that point in life when we place our fate in God's hands, we, too, will sense the presence of an angel from heaven, strengthening us. This is the role taking that the Gethsemane prayer itself invites. By identifying with the one who voiced this prayer—allowing his prayer to speak for us—we have assurance that we, like him, are God's beloved (Luke 3:22), and that we, like him, will know the strengthening presence of the angel from heaven, who is this love personified.

Earlier, I confessed that I do not know all the answers to the weighty questions that are raised in our minds about petitionary prayer and its efficacy, questions concerning whether we should always ask God for what we desire or whether there are times when we should be more reticent; whether our attitude should be one of humility and deference or one of boldness and forceful confidence; whether we should sometimes qualify our requests because we may not be aware of their full implications; and whether we should think of petitionary prayer as a request from a child to a parent figure or whether other images of God—and thus of us—are just as valid. But what I do know is that it is just as legitimate to make requests in our own behalf as to make requests on behalf of others. This is what Jesus himself taught us: As he prayed in his own behalf in the Garden of Gethsemane when he was in deep despair, so we should not hesitate to pray in our own behalf. On this point, I believe that the student chaplain got it right. Mary should have felt perfectly free to ask God to send the spirit of comfort and healing or whatever else it was that she wanted for herself.

What I wish the student chaplain had been more sensitive to, and tolerant of, was Mary's very real questions not only about the efficacy of prayer in her own behalf but also about the propriety of such prayer. Such questions are in the minds of many of us, and they are legitimate questions for us to raise. My concern here has been to make a strong case for the validity of petitionary prayer while recognizing that we will continue to have vexing questions about this form of prayer. In making this case, I have relied strongly on the communication model known as coorientation. But, in doing so, I am not basing my

argument on a modern social scientific concept only, for in my view the most compelling model we have of such coorientation is Jesus' Gethsemane prayer. There is nothing as intensely intimate and dialogical in all Christian literature as this profoundly moving prayer. What is especially striking about this prayer is the utter freedom that Jesus exhibits in pouring his heart out to God. To engage in petitionary prayer as Jesus does is thus to have direct, immediate experience of our Christian freedom. To engage in petitionary prayer is to experience the release of our spirits from these recalcitrant bodies of ours. ☸

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Rest in His Hands. Bronze relief by Käthe Kollwitz, c. 1936.

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Death and Dying Well in the Orthodox Liturgical Tradition

Vigen Guroian

Whether, therefore, we live or die we belong to the Lord. —*Romans 14:8 (New English Bible)*

WE LIVE IN A TIME THAT IS FIXATED upon death. The camera eyes of the culture are drawn to the “death masks” of the terminally ill and those dying of AIDS. Our morbid curiosity about death mixes with our despair that life loses meaning when we are faced with prolonged personal suffering, the infirmities of old age, or terminal illness. With the decline of traditional religion, the resources to die well seem to have dried up. There is renewed interest in old answers of suicide and the deliberate termination of life by medical means. Euthanasia is a topic debated in the medical profession, in state legislatures, in the media, and among people in all walks of life.

Euthanasia, which originally meant simply “a good death,” has come in our time to mean the choice of death as a remedy or end for people suffer-

ing from debilitating or terminal illness. This trend in our society of seeing euthanasia as a solution for pain and suffering was identified by the late Southern writer Walker Percy, who named it the thanatos syndrome. Many Christians are troubled by the thanatos syndrome because it seems to go against central tenets of their faith. The deliberate putting to death of helpless or infirm persons, in fact, could never be countenanced from within my own Orthodox Christian tradition. Nevertheless, euthanasia raises difficult ethical questions about when treatment should be terminated and when suffering should be attended to in order to help those who are dying die as well as possible. Christians and non-Christians who are troubled by the thanatos syndrome and the trend toward euthanasia need to think seriously about what constitutes dying well. They need to commit themselves to giving care for the sick and dying that reflects this value.

“It falsifies the Christian message to present and to preach Christianity as essentially life-affirming—without referring this affirmation to the death of

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Christ and therefore to the very fact of death; to pass over in silence the fact that for Christianity death is not only the end, but the very reality of *this* world.” Thus wrote the late Russian Orthodox theologian Alexander Schmemmann (1973:96) in a discussion of the Byzantine rite of holy unction.¹ Schmemmann argued that the Orthodox tradition embraces neither a morbid religious explanation of death and resignation to it nor a therapeutic affirmation of life that denies the awful reality of death. Not by accident did Schmemmann choose to discuss death and dying within a reflection on liturgy. For within the Orthodox liturgies, especially the rites of holy unction, the prayers for the sick, and the rites of burial, a profound theology of sickness and dying is set forth. Drawing from this rich Orthodox tradition and its realistic theology of death, we can advance our knowledge of theological resources for dealing with sickness, death, and dying, even in the current cultural climate of the thanatos syndrome.

Cultural Confusions over the Meaning of Life and Death: The Case of Baby Rena

IN JULY 1991 THE *WASHINGTON POST* ran a two-part front-page feature on Baby Rena and her tragic death at the age of 18 months from complications of AIDS and heart disease. The first article of the series opened with this paragraph:

Murray Pollack, a physician at Children's Hospital [in Washington, D.C.], felt the time had come to change the rules. His 18-month-old patient, Baby Rena, was dying, a victim of AIDS and heart disease. For six weeks, ever since her arrival at the intensive-care unit in late January, she had been breathing only with the help of a respirator. She was in so much pain that Pollack kept her constantly sedated. When nurses performed even the simplest procedure, such as weighing her, her blood pressure shot up and tears streamed down her face.

But a tube in her throat made it impossible for her to utter a sound. (Weiser 1991a:1)

Pollack had been called in to take the case after Baby Rena was brought to the hospital on January 30 for what was her final stay. She died in the hospital on March 25. From the outset, Pollack judged Baby Rena's case as probably “futile.” Keeping her on the respirator was not a lifesaving measure so much as an intrusion into her dying process which only intensified and prolonged her suffering. Pollack argued that he and the medical staff had “a responsibility to do what's best for Rena . . . , and to give her the appropriate care—and that is not always giving her all care” (Weiser 1991b). Pollack was not advocating mercy killing. Rather he wanted those responsible for her care to “let go,” to let Rena die the death she was dying as well as possible. This he judged meant removing her from intensive care and the respirator. Sedation would relieve her severe pain, and death would likely follow sooner rather than later.

Children's Hospital required the consent of parents or legal guardians before a patient could be removed from a respirator. Because Rena's mother had abandoned her at birth, Rena was the ward of the District. The hospital sought permission to take her off the respirator, but the government denied the request. Although her foster parents had no legal standing in the decision, they strongly objected to Pollack's recommendations. They believed that God had told them “to take the child, and rear her in the nurture and admonition of God's word . . . and to battle the spirits of infirmity” (Weiser 1991a:18). They demanded that her treatment “be motivated by a spiritual sense of obedience to God” (Weiser 1991b).

In the Baby Rena case the foster parents, their pastor, and their friends were significant actors. They all professed a Christian belief in the sanctity of life and God's lordship over living and dying. And yet by the best standards of Christian tradition, I cannot find good cause to agree with either their reasoning or their judgment. Resources in the Chris-

tian tradition enable us to draw a distinction in health care settings between direct killing and allowing to die. The former is euthanasia and is morally wrong, but the latter is not. Allowing to die may sometimes be required by Christian conscience, and it does not fall under moral prohibition. In some circumstances Christians are permitted—even duty bound—to let life ebb away in its natural course. They then are responsible to provide care that relieves pain and comforts the dying.

Too often today, conscientious religious and non-religious people lack the moral means to “see” and accept such possibilities. The issue, like so many other moral controversies, gets framed in either/or terms. Either one believes that everything possible must be done to save life, or one supports euthanasia. The Baby Rena case illustrates how people get trapped in this moral cul-de-sac. In this cul-de-sac, conflicts waged between “religious” and “nonreligious” antagonists may be interpreted by the combatants as positive proof that they are far apart in worldview. In actuality, the conflict often disguises an underlying *secular* outlook shared by the antagonists.

Theological ethicist Paul Ramsey once observed that in our society persons who hold quite opposite positions on euthanasia end by dissolving distinct alternatives to euthanasia. Religious convictions or the lack thereof are not the important determining factors. Ramsey explained:

The case for either [favoring euthanasia or favoring relentless efforts to save life] can be made only by discounting and rejecting the arguments for saving life qualifiedly but not always. In both cases, an ethics of only caring for the dying is reduced to the moral equivalent of euthanasia—in the one case, to oppose this ever, in the other case, to endorse it. Thus the

extremes meet, both medical scrupulosity and euthanasia, in rejecting the discriminating concepts of traditional medicine. (1970:146)

In spite of, or perhaps because of, their simple definition of God’s sovereignty over life and certainly because of an almost Manichaean identification of sickness and death with demonic spirits, the foster

parents of Baby Rena were unable to distinguish caring for the dying, when that might mean letting die, from euthanasia. Ramsey insisted that the traditional ethic (grounded in the belief that God is Creator, Lord of Life, and Redeemer) was clear: “letting life ebb away is *not* the same as actively encompassing a patient’s life” (1970:156). How is it that Baby Rena’s foster parents, who were religious

people, failed to see and act upon this important difference? Why were they held captive to the current popular meaning of euthanasia and the restrictive alternatives of either a utilitarian devaluation of life or an ethical vitalism that mystifies and absolutizes human life?

Alexander Schmemmann had it right when he explained the matter this way. The mark of secularism is the absence of God experienced in the society and in people’s lives. Vast numbers of religious and nonreligious people in our culture carry this mark of secularism in their understandings of God and the world. This is nowhere more evident than in attitudes toward death and dying. The non-religious attribute all meaning in life solely to human agency and humankind’s projects to eliminate suffering, injustice, and the like. God may or may not exist. There may or may not be an afterlife. We probably will never know for sure, and so we proceed as if there were no God. The only life we know we possess is this life. And this life ends

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with death. Nonreligious secularists refuse to “explain the world in terms of an ‘other world’ of which no one knows anything, and life in terms of a ‘survival’ about which no one has the slightest idea.” Rejecting tired religious orthodoxies that see life’s value in terms of death and an afterlife, they turn to explaining “death in terms of life” (Schmemmann 1973:98).

Secular nonreligious people, however, differ among themselves about the scale of value on which human life ought to be measured. Some nonreligious people esteem personal existence as the only concrete value. They adhere to an ethical vitalism that insists upon using every means possible in all circumstances to ward off personal death. Others argue out of a utilitarian framework that the value of a life is qualified by what good or happiness, pleasure or fulfillment might reasonably be expected to be had by living that life. Some lives might not be worth living. We might even choose to end them through rational suicide or euthanasia.

On the face of it, religious people like Baby Rena’s foster parents seem to be the opposite of these secular, nonbelieving people. They want to measure all value in terms of a spiritual “other world.” What they hold in common with their nonreligious opposites, however, is a view that this world is essentially meaningless. These two worldviews are complements of a unified secularism. From the standpoint of the classical Christian understanding of life and death and how God is related to them, these contemporary religious

and nonreligious outlooks both devalue the world and empty it of God’s presence. The difference between the two outlooks occurs at the pragmatic level when one determines how an essentially meaningless and valueless world is lent meaning and value. As I have suggested, those at the nonreligious pole of secularism believe life obtains meaning through human endeavor. Contrarily, those at the religious pole of secularism insist that God is the only meaning-giver. God is spiritual, and the only true meaning in life is gained on the spiritual level of our existence, which is radically distinguished from this world.

I believe the religion of Baby Rena’s foster parents approximates this secularly religious worldview. At the root of the foster parents’ religion is a metaphysical and moral dualism that radically separates physical existence (this world) from spiritual existence (the other world). This body and spirit dualism moved an otherwise loving father to insist that the extreme physical pain being endured by his small child had to be continued. But what does it mean to care for the spiritual well-being of a beloved one who is dying if that care does not regard the physical pain and dying which she is enduring? During one conversa-

tion between the hospital staff and the parents, the father sketched three pictures representing Rena’s body, soul, and spirit. The father said, “We see that she has AIDS. It’s real, because you can see it under the microscope.” He went on to thank the hospital staff for working hard to meet her medical needs. He added, however, that her spiritual side had been

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ignored. Pointing to the third sketch, he said, "It seems to me that until the hospital really addresses the spiritual area we won't be able to defeat these various spirits of infirmity, including AIDS, that we're fighting against here." He explained the couple's belief that the decisions for Rena needed "to be motivated by a spiritual sense of obedience to God. It's most important to find out what God desires or what God wills for Rena." At one point, a hospital social worker made this observation to the parents: "What you're saying is that you don't want to give up on the spiritual part even though we're giving up on the physical part." The father nodded. He recalled Rena's earlier recovery, when the hospital staff had given up hope. "If we give up now, we won't fully understand," he said. "We won't fully know that God's word is true" (Weiser 1991b).

The father spoke of the necessity of discovering what God wanted as if that was not already discernible at the level of Baby Rena's fleshly suffering and dying. What were the parents waiting for as a sign of God's will being revealed? Again, as Ramsey so aptly put it: "No Biblical theologian [or Christian] should take umbrage at the suggestion that a pronouncement of death [or for that matter a judgment about when death is imminent or further medical treatment is futile] is a medical question. What personal life do we know except within the ambience of a bodily existence?" (1970:61). God does not need respirators to work miracles, but God entrusts to our physicians determinations of when we are biologically dying, whether the physicians themselves trust in God or not. One writer of a letter to the editor questioned the parents' identification of God's will with doing everything possible to keep Rena alive.

I hope that people reading the article on Baby Rena do not get the impression that keeping her on the respirator was the only decision that people with faith in God could have made. . . .

Having faith [sometimes] requires people to voluntarily give control over a situation to God. Although giving up control is the key to doing God's will, you still need to figure out

what it is that God wants you to do—that's the hard part. (Michelizzi 1991)

In *The Patient as Person*, Paul Ramsey ruminated,

It may be that only in an age of faith when men know that dying cannot pass beyond God's love and care will men have the courage to apply limits [to lifesaving interventions] in medical practice. It may be that only upon the basis of faith in God can there be a conscionable category of "ceasing to oppose death," making room for caring for the dying. It may also be that only an age of faith is productive of absolute limits upon the taking of the lives of terminal patients, because of the alignment of many a human will with God's care for them here and now, and not only in the there and then of his providence. (1970:156)

Baby Rena's parents were far more fixed upon the "there and then of [God's] providence" than they were able to discern the "alignment" of the many human wills involved in her care "with God's care." This fixation on the "there and then" and depreciation of the "here and now" belongs to a spiritualism and otherworldliness which is the symptom and product of secularism itself, not its opposite as those who hold such religious views invariably think. Ironically, secular Christianity and modern fundamentalism of the kind evidenced by Baby Rena's foster parents can be one and the same. If the non-religious expression of secularism is the desacralization of human life and the experienced world, then Christian or Jewish secular religion entails the breakdown of the symbolic and sacramental structures in and by which persons and communities relate God and world so that God is experienced as both transcendent over the world and wholly manifest within it. In spite of the foster parents' repeated appeals to God and God's law, they simply could not see that in the "here and now" God's encompassing love might permit the practical distinction between direct killing and letting die.

The articles in the *Washington Post* did not say whether Dr. Murray Pollack was a religious man.

Nevertheless, his practical conclusions about treatment for Baby Rena were much closer than her foster parents' opinions to the classical Christian conviction that God's care can be aligned with human reason in discerning when life is ebbing and need not be heroically extended. I say this with one very important qualification: nothing in the criteria of futility and quality of life that Pollack depended upon for his ethical judgment indicates the distinction drawn between allowing to die and putting to death. We are not told whether Pollack considered euthanasia as a possible solution. But nothing in the description of Pollack's reasoning prevents the conjecture that he could have advocated such a course of action and still been consistent with his ethical standards. It has been argued, contrary to Ramsey's opinion, that belief in the biblical God is not a necessary precondition for having good reasons to prohibit or at least severely limit euthanasia or, on the other hand, "to apply limits" to saving life (see, for example, Childress 1981: chap. 2). But neither Ramsey's argument nor the arguments of his challengers are logically conclusive.

Still, I side with Ramsey. In the relatively rarified atmosphere of medical ethical discourse, we may well be able to conjure principles and rules that secure a distinction between killing and letting die. But Ramsey's argument is more realistic regarding what counts for authority within a culture and the powerful moral role that biblical theism once played but no longer plays in this culture. Specifically, biblically rooted theism provided people with the conviction that God, the absolute source and sustainer of our being and our redeemer, is with us in death as much as in life. As St. Paul said in Romans 8:38–39, "neither death, nor life, . . . nor anything else in all creation will be able to separate us from the love of God."² Biblical theism gives a vision of the ultimate good of the person. The momentum in the culture is demonstrably toward utilitarianism and secularism, which lack this conviction and do not supply a strong vision of human ends. In such circumstances it is difficult to sustain a distinction between killing and letting die—not even by inde-

pendent rational appeal to such principles as trust between patient and physician or nonmaleficence. In such a cultural milieu the distinction has no rudder, and the formal principles and rules get tossed about like debris on floodwaters.

Any discussion of the resources within the Orthodox liturgical tradition for an ethic of death and dying risks perfect abstraction and virtual irrelevancy if the present cultural situation and the moral confusions even among self-described religious people are not understood and taken into account. Nevertheless, I strongly believe that an exploration of this religious vision of living and dying can give guidance not only for those who profess and practice a biblical faith but also for nonreligious people who conscientiously seek every available resource for doing what is right for the terminally ill and dying. The Orthodox rites of burial and of anointing the sick provide means for overcoming the false reasonings, moral dilemmas, and confusions that hamper our ability to see clearly when we face the issues of terminal illness. In these rites and prayers abide valuable ethical insights that can restore moral vision to our care for the dying.

The Byzantine Rite of Holy Unction

THE ORTHODOX RITES OF BURIAL and of anointing the sick are rooted in the biblical persuasion that death and sickness cannot be understood apart from sin: "the wages of sin is death" (Romans 6:23), and "the sting of death is sin" itself (1 Corinthians 15:56).

St. Paul's writing is not the only Christian Scripture to make this connection between sin and death. It is found in the Gospels also. We need look no further than the second chapter of the Gospel of Mark for a powerful narrative presentation of the reality of sin in death. At the beginning of the chapter, the story is told of Jesus' healing of the paralytic in Capernaum. Word had gotten out about



November Landscape. Oil on fabric by Charles Warren Eaton.

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Jesus' return to that region, and "some people came, bringing to him a paralyzed man" (Mark 2:3). The man was lowered through the roof of the house in which Jesus had been staying. When Jesus saw the faith of the man and his friends, the Gospel writer reports that Jesus "said to the paralytic, 'Son, your sins are forgiven.'" This response is bound to strike the ears of modern folk as a bit strange. Jesus does not immediately heal the man. Instead, he forgives him his sins. Only after his authority to forgive sins is questioned by certain scribes, who "were sitting there" does Jesus proceed to heal the paralytic of his physical ailment. "'But so that you may know that the Son of Man has authority on earth to forgive sins,'—he said to the paralytic—'I say to you, stand up, take your mat and go to your home.' And he stood up, and immediately took the mat and went out before all of them" (Mark 2:5, 6, 10–12).

This Markan lesson about the connection between sin and sickness is sealed later in the chapter when the story is told of Jesus' visit at the house of Levi the tax collector and his meal with certain "sinners." Pharisees saw this and "said to his disciples, 'Why does he eat with tax collectors and sinners?'" When Jesus heard this, he said to them, "Those who are well have no need of a physician, but those who are sick; I have come to call not the righteous but sinners" (Mark 2:16–17). The Matthean version of this story (Matthew 9:9–14) is read in the Byzantine rite of holy unction.

Set these portions of the biblical narrative beside the commonly held understanding that the practice of anointing the sick is merely about curing physical or psychological illness, and one begins to see the extent to which the biblical belief about the relation of sin, sickness, and death has broken down in our culture. The anointing of the sick and dying is *first* about penance and forgiveness of sins. The deep meaning given to healing in the rite of holy unction eludes us if these central themes of penance and forgiveness of sins are forgotten. The Byzantine rite opens with the whole of Psalms 143 and 51, from which a few stanzas are quoted here:

Hear my prayer, O Lord;
give ear to my supplications in your
faithfulness;
answer me in your righteousness.
Do not enter into judgment with your servant,
for no one living is righteous before
you. . . .

Answer me quickly, O Lord;
my spirit fails.
Do not hide your face from me,
or I shall be like those who go down to the
Pit.
Let me hear of your steadfast love in the
morning,
for in you I put my trust. . . . (Psalm
143:1–2, 7–8)

Have mercy on me, O God,
according to your steadfast love;
according to your abundant mercy
blot out my transgressions.
Wash me thoroughly from my iniquity,
and cleanse me from my sin.

For I know my transgressions,
and my sin is ever before me.
Against you, you alone, have I sinned,
and done what is evil in your sight,
so that you are justified in your sentence. . . .
Indeed, I was born guilty,
a sinner when my mother conceived me.

You desire truth in the inward being;
therefore teach me wisdom in my secret
heart.
Purge me with hyssop, and I shall be clean; . . .
Let me hear joy and gladness;
let the bones that you have crushed rejoice.
Hide your face from my sins,
and blot out all my iniquities.

Create in me a clean heart, O God,
and put a new and right spirit within
me. . . .
Restore to me the joy of your salvation,
and sustain in me a willing spirit.
(Psalm 51:1–10, 12)

In the Old Testament, the Hebrew for *salvation* derives from *yasha*, which means “to save from a danger.” Salvation in these psalms is intimately connected with themes and metaphors for healing of body and soul. God delivers us—literally snatches us—not only from our enemies and from persecution but from sickness and the power of death. In the New Testament, the Greek *sozo*, meaning “salvation,” comes from *saos*, which means “healthy.” Prayer and penance for the sin that attaches to all “flesh” and makes that flesh subject to a corruptible death (the destruction of the unity of body and soul) issue from the belief that God wants to heal all our infirmities. Penitential prayer issues also from the conviction that this healing is a part of the whole process of salvation. A reading from the Epistle of James in the Byzantine rite makes the church’s belief abundantly clear.

Be patient, therefore, beloved, until the coming of the Lord. . . . As an example of suffering and patience, beloved, take the prophets who spoke in the name of the Lord. Indeed we call blessed those who showed endurance. You have heard of the endurance of Job, and you have seen the purpose of the Lord, how the Lord is compassionate and merciful. . . .

Are any among you suffering? They should pray. Are any cheerful? They should sing songs of praise. Are any among you sick? They should call for the elders of the church and have them pray over them, anointing them with oil in the name of the Lord. The prayer of faith will save the sick, and the Lord will raise them up; and anyone who has committed sins will be forgiven. Therefore confess your sins to one another, and pray for one another, so that you may be healed. The prayer of the righteous is powerful and effective. (James 5:7, 10–11, 13–16)

References to prayer, penance, forgiveness of sin, healing, and salvation are joined together in this passage. Anointing with oil is the sign and sacrament of these divine and human healing actions. According to the rite, the actual anointing of the sick or dying person follows soon after this reading,

but not before the story of the good Samaritan is recited also. God’s love and mercy are like that of the Samaritan. We can have hope in the face of sickness and death because love like that of the Samaritan is the very being and character of God. From this we also gain assurance that God forgives us our sins, heals us, and raises us to life eternal. “For thou art a great and marvelous God, who keepest thy covenant and thy mercy towards them that love thee; who givest remission of sins through thy Holy Child, Jesus; who regeneratest us from sin by Holy Baptism, and sanctifiest us with the Holy Spirit; who givest light to the blind, who raisest up them that are cast down, who lovest the righteous, and showest mercy unto sinners; who leadest us forth again out of darkness and the shadow of death,” says the prayer that immediately follows the reading of the story of the good Samaritan (*Service Book of the Holy Orthodox-Catholic Apostolic Church*, p. 344).

The Messiah, wrote Paul Ramsey, did not “bear epilepsy or psychosomatic disorders to gain victory over them in the flesh before the interventions of psychoneurosurgery. Rather is he said to have been born *mortal* flesh to gain for us a foretaste of victory over sin and death where those twin enemies had taken up apparently secure citadel” (1987:192). The healing done by Jesus is not merely a metaphor or an external sign for salvation. It is a deep symbol, a sacrament of salvation binding together heaven and earth and leading to eternal life. All of Jesus’ miraculous healings are signs and foreshadowings of his victorious death on the cross through which we gain entrance into the kingdom of his Father.

Further, the God whose love is “steadfast” and whose “mercy is abundant” could never euthanize. It is in the character of God to act finally to save all fleshly, personal life. From a Christian standpoint, euthanists’ motives, however humanitarian or well-intentioned, can never justify what they do. The aim of their euthanizing is more important than their motives in evaluating the rightness or wrongness of the act. That aim is contrary to everything God intends and does for us in a fallen and sinful world which, absent his presence and saving activity, is a

cosmic cemetery (see Meilaender 1987, esp. 455–57). There is a difference between a God-centered humanism and a naturalistic humanitarianism. Christians must insist upon that difference. While they may grant the good intentions of those who in the name of humanitarianism practice euthanasia, Christians are bound to condemn those euthanizing acts as wrong and sinful.

Rites of Burial

ANOINTING IS NOT CHRISTIAN MAGIC, and anointing of the sick and dying is no substitute for medical care and treatment. Rather, performing penance and asking God to forgive the sick person's sins are healing practices that are related to a broader and deeper understanding of health than the naturalistic and mechanistic understanding often found in modern medical practice. Health, rooted in incarnational faith, has sacramental, soteriological, and eschatological dimensions displayed in the Byzantine rite of holy unction.

The Armenian Orthodox rite of burial of laypeople uses the same themes of penance and atonement encountered in the Byzantine rite of holy unction. It sets forth, however, a far more exhaustive theology of the Incarnation. The incarnation of God in human flesh is the church's answer to death.

The burial rite displays the Christian conviction that care for the dying is care for that flesh among us that is near to the end of the perishing in which we all participate from birth through death. Christian care for the dying values this flesh not only because God created it but because God's Son assumed it as his own form of living and dying. Despair over the perishing of flesh represented in acts of suicide and euthanasia is not only unreasonable but irreverent from the standpoint of the Christian story of creation and salvation.

In the great prayer attributed to St. Basil in the Armenian rite of burial, this story is narrated with profound implications for those who believe that Jesus Christ is Lord and Savior. Christians must

dispose themselves toward living and dying as Christ did. The following passages from that prayer are representative of its principal theological statements.

We thank thee, Father of our Lord Jesus Christ who because of thy love of mankind has visited us, and saved [us] from the machinations of the traducer [of] the race of men that were driven out and banished afar. For Satan was jealous of us, and drove us out of eternal life by his deceits and wiles, proscribing and banishing us unto our destruction and ruin. But thou, O God, who art benevolent and lovest man, didst not permit the bitterness of his poisoned fangs to remain in us. Wherefore thou didst summon death, and poured it out upon creatures, in order that the wickedness that had befallen might not remain immortal: but by removing us from this life, and cutting us off from our sins, the punishment of the beneficent One became salvation.

But in the last days thou didst send thy only-begotten Son, beloved in the image of the death of sin; and he condemned sin in his own body, and by his voluntary crucifixion shattered the hosts of the enemy. He became the firstfruits of them that slept, and by his divinely marvelous resurrection he invited us to share in his own immortality.

Now this thy servant believing in him has been baptized into the death of thy Christ. . . . [R]emit to this man his debts incurred either willingly or unwillingly, and heal all the wounds which the disincarnate enemy hath inflicted. . . .

And now do thou heal his wounds, and convey him peacefully past the principalities of darkness, . . . and efface the handwriting of their influences and inworkings, which they have sown in him and vouchsafe to him a goodly journey. . . . [L]et him through [the path of the Tree of Life so that he may] arrive at the place of safety where all thy saints are massed and wait for the great wedding, when the great God and Savior shall appear, Jesus Christ, at the sound of the great trumpet. . . . Then . . . at the glance of the judge the earth shall be shaken, and the sealed sepulchres be opened. The bodies that were turned to dust

are built up afresh, and the spirits swooping down like eagles reach them and array themselves in the incorruptible body. (*Rituale Armenorum*, pp. 130–31)

One has to marvel at this prayer. For in it virtually all of the church's theology of death is powerfully and poetically expressed. One should also recognize that in a culture where belief in the soul and in the immortality of flesh and spirit is all but lost, those that would pray this prayer in their care for the dying and take it to heart as physicians, nurses, or family members are bound to look odd, even to the most goodwill observer.

What is perhaps most incomprehensible to modern people is the belief that death's reality is more than biological or physical. This prayer and the whole of Orthodox tradition inform us that death is also spiritual. The full ramifications of our dying extend beyond the otherwise medically useful fiction of a precise moment of death measured in terms of the cessation in brain function or the "closing down" of the body's system of vital organs. As Schmemmann puts it, "in the Christian vision, death is above all a *spiritual reality*, of which one can partake while being alive, from which one can be free while lying in the grave" (1974:62). This spiritual definition of death does not entail a Platonistic dualism of body and soul. And it is very different from familiar, modern notions of the mortality of the body and the immortality of the soul. Spiritual death, in the classical Christian understanding, happens and is defined in strict relation to the body. It encompasses our whole being, whereas medical definitions of death do not (and need not) take the whole person into account.

**The resources that the
Christian faith holds for living
toward our dying in freedom
and with hope and courage
cannot be instantaneously
transmitted to the sick person
waiting upon death
whose flesh already is ravaged
and whose mind is
tormented by disease.**

If one were to say that death, spiritually understood, includes what we call the human psyche, perhaps the modern mind would begin to grasp what is meant. Clinically identifiable depressive illness and behavioral disorders might be invoked as examples of what is being referred to, leaving aside all the ways in which human beings fail to love, learn to hate, and so forth (which psychological and psychiatric sciences place within the range of normal human behavior). But the psychological is not the whole of what classical Christian belief has in view either. Spiritual death is here and now and forever after. It involves the soul *and* the body. It is eschatological. The Armenian rite describes the nature of this death as expulsion from the garden with the Tree of Life. This means separation from God, who is the sole giver of life. Death Christianly understood is not the same as personal extinction; it is not the opposite of immortality.

Only God has the power to annihilate our existence. And God will not will it. But we have the power to reject the true Life, which "was the light of all people" (John 1:4). Sinful is the nature of the creature alienated from God, or true Life. The death referred to in the prayer of St. Basil brings an immortal death: an unceasing separation from God. That separation begins in the here and now. A sign of this separation from God is our separation from our fellow human beings. True communion with others is missing from our lives. We long for it but do not grasp it; paradoxically, we habitually reject it. (In the language of this culture *communion* is translated into *communication*, but this translation misses the depth of meaning.) We all sin, and we all experience desolation.

Death understood in its spiritual reality threatens personal existence with another form of separation or alienation—the separation of the soul from the body. This has been called corruptible death by the great fathers of the church. It is the actual decomposition of the body-soul unity, a fading away of the image of God in the human being, that constitutes the living person. The anthem of St. John of Damascus in the Byzantine rite of burial exclaims, “I weep and wail when I think upon death, and behold our beauty, fashioned after the image of God, lying in the tomb disfigured, dishonored, bereft of form” (*Service Book*, p. 386). The Armenian prayer states that such a death “was summon[ed] by God and poured . . . out upon creatures, in order that the wickedness that had befallen might not remain immortal” (*Rituale Armenorum*, p. 130).³ Note that the prayer does not say that God created death. Rather, God allowed the natural inclination of the creature toward dissolution to go its way.

Although this complete dissolution of the person is death in all its horror, the very process of dying itself holds a terror for all human beings, even those uninformed by such an understanding of personal existence. This terrifying experience anticipates the final end. For we have the sense when sick or dying that we are losing control of our body and with it our very identity and our whole world, both personal and impersonal.⁴ For it is only in and through this body, this flesh in its wholeness and integrality with soul and psyche, that we are able to participate in the world. (This capacity and state of being which we are losing we call *health*.) The experience of the dissolution of our being and loss of our world is more profoundly real than any secular psychological or social science is able to comprehend because it extends beyond the scope of such science, beyond

space and temporality into eschatological time.

The Byzantine rites include a prayer for the parting of the soul from the body, which is spoken when physical death is near. It, in fact, beseeches God to bring this process to a conclusion by allowing the “destructible bond” of body and soul to “be dissolved,” “the body to be dissolved from the elements of which it was fashioned,” and the soul to be

“translated to that place where it shall take its abode until the final Resurrection” (*Service Book*, p. 366). The Armenian prayer completes this picture of death when it envisions reconstituted, resurrected humanity: “The bodies that were turned to dust are built up afresh, and the spirits swooping down like eagles reach them and array themselves in the incorruptible body” (*Rituale Armenorum*, p. 131). The

image of God within us thus is restored. The Byzantine and Armenian prayers together present the picture of a spiral of life and death.⁵ The Byzantine prayer identifies the nadir of death, the very bottom of the spiral. The Armenian prayer captures the beginning of the curve upward again beyond earthly life into eternal life.

The Incarnation makes this a spiral and not a circle. Not only has Christ repeated or recapitulated in his living and dying our living and dying, he has added something new. Whereas Adam was disobedient unto sin and death, as have been all his sons and daughters, Christ, the new Adam, was obedient unto new and eternal life. Christ opens up the possibility of eternal life in the presence of God. This was closed to Adam and Eve when they were expelled from the garden. The circle of sin and death opens into a spiral leading to new life with God. The Armenian prayer of St. Basil presents this theological linchpin of the Orthodox understanding of death tersely and forcefully.

**A condescending cheerfulness
and insistence on Christian
hope can be just as alienating
and tormenting as an
insensitive or morbid
preoccupation with sin and
making amends.**

But in the last days thou didst send thy only-begotten Son, beloved in the image of the death of sin; and he condemned sin in his own body, and by his voluntary crucifixion shattered the hosts of the enemy. He became the firstfruits of them that slept, and by his divinely marvelous resurrection he invited us to share in his own immortality. (*Rituale Armenorum*, p. 130)

From this vantage and this vantage only can sense be made of the Easter proclamation that death has been overcome once and for all in Christ Jesus. For it is this mystical death, of which “physical” death is only a part and a visible sign, that Christ came to destroy and abolish. Christ has taken the sting, the spiritual poison of sin, out of death by denying it a final eschatological triumph over life. Through his own voluntary death on the cross, Christ has transformed dying and death into a passage and entrance into a fuller life of communion and love with God and his saints (Schmemmann 1974:64). The physical death that medicine knows, studies, and endeavors to delay is not something that Christ necessarily came to abolish. It certainly is not the whole of what he did abolish. But neither do we have permission to inflict that death upon the sick and innocent. For “whether . . . we live or die we belong to the Lord” (Romans 14:8). The life we have is a gift. In George MacDonald’s wonderful tale *The Princess and the Goblin*, the mysterious great-great-grandmother presents the child princess Irene with a magic ball of thread and then returns it to a drawer while fastening the end of it to Irene’s ring. Irene asks if she has done something wrong that might account for the grandmother’s taking back the ball of thread. “No, my darling,” says the grandmother. “But you must understand that no one ever gives anything to another properly and really without [also] keeping it. That ball is yours” (MacDonald 1986:101). The divine gift of life is a gift given yet still “kept” by God. This gift of life is God’s ultimately to dispose with as he chooses. It is not ours to take from another or ourselves.

The Church and Caring for the Dying

THE TRUTH ABOUT LIFE AND DEATH and living and dying which the church embraces and proclaims in its liturgies and rites is not one easily understood or accepted by people in the contemporary world. In his last novel, *The Thanatos Syndrome*, Walker Percy identified and explored the disagreement between modern secularism and Christianity over the meaning and end of life. In the novel, we are introduced to the eccentric character of Father Simon Smith, who has fled from his responsibilities in a hospice and is holed up at the top of a fire tower where he prays and meditates. Some in the community view Father Smith as a failed priest. But there is more to Smith’s “failure” than meets the eye. His failure is that he will not assume the role of a divine therapist for the modern narcissists who populate Feliciana Parish—those respectable, successful folk whom he addresses in his sermon at the novel’s close. “I don’t see any sinners here,” he says. “Everyone looks justified. No guilt here” (Percy 1987:360).

Yet these words are a clue to the only possible reason that Father Smith went up to the tower in the first place as well as the reason he finally comes down. Jan Greene, the sharp-witted wife of a physician (and herself a practicing Roman Catholic), gets it right. During a conversation about Smith, she snorts, “For God’s sake. Like Jonah. I mean, really. Has it ever occurred to anybody that he might be up there for a much simpler, more obvious reason? . . . He could be doing vicarious penance for the awful state of the world” (Percy 1987:112–13).

Father Smith will not turn his face from the evils being committed around him, especially the false care for the dying in the government’s “Qualitarian centers,” where abortion and euthanasia are routine therapies for the physically and mentally impaired, for the “unwanted” and socially “useless.” Nor will he withhold judgment of people who want to believe that we have no final accountability for our lives,



Passage of a Soul. Etching by Odilon Redon, 1891.

Photograph © 1993, The Art Institute of Chicago. Stickney Collection. 1920.1543. All rights reserved.

that all we need expect of ourselves is to be well-adjusted, tolerant of others, and “decent” toward our fellow human beings, even, in fact especially, when putting them to death. In a society like ours, the capacity to rationalize the killing of fetuses and suffering people knows no limit. Rights are invented to inflict death upon others as we would have others do it unto ourselves.

Thus Smith pleads in his sermon, “If you have a patient, young or old, suffering, dying, afflicted, useless, born or unborn, whom you for the best of reasons wish to put out of his misery—I beg only one thing of you, dear doctors! Please send them to us. Don’t kill them. Please send them to us! I swear to you you won’t be sorry. . . . [W]e will even call on you to help us take care of them! . . . God will bless you for it” (Percy 1987:361). One wishes the church was, in fact, better prepared to prove to this society the moral correctness of Father Smith’s way. One wishes that the church would express more strongly its deepest convictions about life and death and provide more institutions and services to meet the needs of the sick and dying.

Two tenets of Christian faith, then, demand greater attention from the church as it responds with compassion to the sick and dying. These are hard truths in any time, and they certainly run against the utilitarianism, narcissism, and therapeutic ethos of our own time. The first is that sin and death are mystically related. This reality calls for penance, not understood merely in punitive or juridical terms but as a healing sacrament. The second is that the Incarnation and Resurrection place on the church responsibilities for healing and offering hope.

Sin and Penance

Some are bound to object to the extraordinary attention given to sin and penance in the Orthodox rites. They will want to dismiss sin and penance as inappropriate reference points in the care of the sick and dying. What a cruel thing to impose on people who are weakened with sickness or facing their own

imminent demise. For sure, these themes can be twisted and misused by those commissioned to practice the theology of the church in the settings of pastoral and medical care. Condescension and a punitive impulse often turn what is supposed to be healing into another form of torment for the afflicted.⁶ Among the clergy and laity of every church we find the contemporary counterparts of Job’s so-called friends, who either out of an inflexible orthodoxy or for more subjective reasons only add to the suffering of the afflicted by judging them in the place of God or reminding them incessantly of their failures.

These misuses of a penitential theology, however, do not discredit the church’s profound and practical wisdom in placing repentance and forgiveness at the center of its prayers for the sick and dying. This centrality makes perfect sense in light of the Gospels and indeed the whole of Scripture. The Bible and the Orthodox tradition, we have seen, hold that sickness is often enmeshed, “consciously or not, in the complexities of sin, personal and/or social,” as theologian Thomas Oden (1983:251) puts it. This does not require that sickness be understood as punishment for individual sins. (Jesus, in fact, repudiates such a view in Luke 13:3–4.) Nevertheless, a connection between sickness and death with personal sin is not ruled out. This biblical truth is confirmed in “the statistical correlation [we find] between [voluntary] overeating [gluttony] and heart disease, or sexual license with venereal disease” and AIDS, or compulsive drinking with liver disease (Oden 1983:251). It may even be appropriate sometimes in a pastoral relationship to remind persons of the sins they have committed and forgotten or repressed when a connection between such behavior and their sickness is comprehensible.

The Orthodox rites wisely take into account the personal burden of guilt and remorse that weighs especially onerously upon people when they are sick or dying. In such circumstances, the wrongs and injustices that we have committed over a lifetime can suddenly return to haunt us in devastating ways. They may confound deeply and existentially what

meaning we have made of our lives. Thus we may desire some way of accounting for our failures and transgressions. In Iris Murdoch's *Nuns and Soldiers*, Guy Openshaw, an atheist dying of cancer, says to Anne Cavidge, an estranged nun, "I wish I believed in a hereafter. . . . Not for any vulgar reason of course. Not just to be let off this thing that's happening in the next few weeks. But—it's something I've always felt. . . . I would like to be judged." Guy explains further that he would like assurance of having "a clear account" of his life and that his life project should have some consequences, even if these include punishment. But why an afterlife, Anne presses. "Oh but I can't see," Guy answers. "I would want to understand it all. I would want to have it exhibited, explained. That's why the idea of purgatory is so moving" (Murdoch 1982:66–68). The church's serious regard for sin and penance answers such needs and helps us to see how our living and dying are of consequence.

The theme of forgiveness is closely related to the above, as is the notion that dying persons have a responsibility to die in a manner that contributes to the good of the community that has nurtured them. This need to be forgiven and to forgive and the responsibility to express goodwill and trust toward those with whose lives one's own life has been bound are reflected in the Armenian rite for communion of the sick. The rubrics indicate that the priest shall take "the saving mystery and the cross and censer . . . , and go to the sick man. . . . But it is *fitting* that the sick man should first hold converse with his intimate friends or with anyone else with all vigilance and circumspection. And if he has any grudge against anyone, he shall forgive him" (*Rituale Armenorum*, pp. 114–15; my emphasis).

These rubrics nicely anticipate yet another characteristic of the prayers in the Orthodox rites. The prayers set personal sin firmly within a social matrix of evil and suffering. This holds true especially when death is understood theologically as a consequence of sin. We all abide and participate in Adam's sin; we are one mystical body of fallen humanity condemned to death. Thomas Oden observes correctly

that the greater emphasis in Scripture is on a social or corporate fact of sin which redounds to the suffering and dying of us all (1983:251). Our personal sins, though they may not alone account for our own illness, may in combination with the sins of others bring suffering upon still others. Stress in the workplace, for example, is inevitably bound up with the lying, deception, vengefulness, and manipulation in which we all engage. Our institutions in turn take on the character of this collective sin. We now are beginning to understand just how much, for example, the stress created by the social and institutional matrix of injustice contributes to physical and psychological illness.

A prayer in the Byzantine rite of holy unction expresses this idea of the social matrix of sin and injustice:

Yea, O Lord who art easy to be entreated; who alone art merciful and lovest mankind, who repentest thee of our evil deeds; who knowest how the mind of man is applied unto wickedness, even from his youth up; . . . and didst thyself become a created being for the sake of thy creatures; thou hast said: I am not come to call the righteous but sinners to repentance. . . . Do thou O tender-hearted Master, look down from the height of thy sanctuary, overshadowing us sinners, who are also thine unworthy servants, with the grace of the Holy Spirit, at this hour, and take up thine abode in thy servant, _____, who acknowledgeth his (her) iniquities and draweth near unto thee in faith. (*Service Book*, p. 347)

The prayer wisely does not fix upon the sins of the individual alone. Instead, it calls to attention also the sins of family and friends who gather at the bedside or in the church during the performance of the rite. This principle should necessarily extend to all pastoral care. Especially in the case of medical care it guards against the further intensification of feelings within the sick person of failure or alienation from the healthy. The prayer contributes toward the reconstitution of the church as a community of sinners and penitents aware of their common frailty

and mortality who, in the words of the Armenian service for communion of the sick, look together to God “for wholeness of souls and bodies, . . . and for the perfection of good works and of all virtues” (*Rituale Armenorum*, p. 116). The healthy are reminded that they are not so very different from the afflicted in their midst.

Healing and Hope

THE CHURCH’S THEOLOGY OF RESURRECTION and eternal life is, of course, the obvious place to locate a resource of hope in the care of the sick and dying. But this theology, like the theology of sin and penance, is subject to much abuse. A condescending cheerfulness and insistence on Christian hope can be just as alienating and tormenting as an insensitive or morbid preoccupation with sin and making amends. The strong emphasis on sin and penance in the Orthodox rites, however, precludes this cheapening of the hope in the resurrection. Christ died for the *sins* of all to remove the curse of guilt and abolish death, with its sting of emptiness and desolation. Through his dying and our participation in it, death is transformed into a passage to eternal life. Death, which was the wages of sin, becomes the end of sins. God does not remove all the pain and anguish of dying. Christ himself experienced that pain and anguish. Living in the hope of the resurrection, however, means having faith that God can reach, in historian Jaroslav Pelikan’s words, “even into the hollowness of nonexistence . . . to confer life” (1961:27).

Conclusion

I HAVE SOUGHT IN THIS ESSAY to illumine the theological convictions within the Orthodox tradition that define its understanding of death, euthanasia, and care for the dying. Yet these convictions, I know, will have difficulty getting a full hearing in this society. Walker Percy rightly showed

that Father Smith’s position is perceived as something extreme. This is because we are advancing rapidly toward the “Qualitarian” and utilitarian ethos depicted in *The Thanatos Syndrome*.

It is therefore no small task to put into practice an Orthodox and Christian ethic of care for the sick and dying in an increasingly secular environment. A culture once deeply informed by biblical faith is fast losing memory of the reasons that it has objected to the casual taking of life. In this environment, Christians must concentrate more of their energies into the ongoing life and instruction of the church itself. The ethic I describe is first a church-centered ethic: it cannot be disconnected from the community of faith in which it is received and practiced. It is not reducible to a set of universalizable principles and rules taught as such in traditional courses of professional or medical ethics, which are aseptic regarding tradition. It is an ethic intimately joined with the cardinal convictions and narratives of the Christian faith regarding creation and redemption. It is for a people who have been formed by these convictions and stories and who have received the care of the church, starting with baptism. It is naturally located within a larger tradition of pastoral theology and practice. Care for the sick and dying begins with care for the healthy and living. The sacraments, Christian catechetical instruction, and preaching are the precedents and in some real sense the prerequisites of the ethic I describe. The resources that the Christian faith holds for living toward our dying in freedom and with hope and courage cannot be instantaneously transmitted to the sick person waiting upon death whose flesh already is ravaged and whose mind is tormented by disease. The meaning for living and dying that faith provides must be owned by the person over a lifetime.

Yet at the risk of sounding self-contradictory, I should state that even as I believe the primary location of the ethic explored in this essay to be ecclesial, the church’s own special ministry of healing need not, indeed must not, be limited to believers. Some people hold secular outlooks on medical ethics that converge with the diagnoses,

prescriptions, and prognoses of the church. These people will see in limited but crucial ways the truth in Christian ethics. Others can be persuaded. Christian medical professionals who bring their faith into their practice can make a difference for sick people who do not believe in the God of Jewish and Christian Scriptures. I stand with ethicist William F. May when he states that “it is pure angelism to assume that the sole witness of the church to the dying and the bereaved is the testimony of theology alone. A

ministry to the flesh is a true and valid ministry” (1987:181). Even beyond this, biblical faith and Christian theology have the power to comfort and heal persons outside the church. This I hold to be true because the Word assumed flesh, a flesh that all human beings have in common. We live and die as one humanity. The Son of God demonstrated this when he endured death for the salvation of all on the life-giving cross. ☉

NOTES

I wish to express here my indebtedness and gratitude to the late Paul Ramsey, who strongly encouraged me to write a piece on this topic.

1. My use of *Byzantine* here indicates rites belonging to churches such as the Russian and Greek, which have a direct origin in Byzantine Christianity. These churches are usually called Eastern Orthodox. There is, however, another group of Orthodox churches, the Oriental Orthodox, among which are the Coptic and Armenian churches. These churches are also called non-Chalcedonian Orthodox churches because they rejected the christological formula issued by the Council of Chalcedon in 451. The rites of these churches often differ significantly from the Byzantine. I have chosen *Byzantine* to describe the Greek and Slavonic rites cited in this paper. Below, I discuss Armenian Orthodox rites and prayers, which must be distinguished from the former.
2. All Scripture references are to the New Revised Standard Version, except as otherwise indicated.
3. Gregory of Nyssa says the same: “Divine providence introduced death into human nature with a specific design so that by the dissolution of body and soul, vice may be drawn off and man may be refashioned again through the resurrection. . . .” Quoted by Georges Florovsky in *Creation and Redemption*, vol. 3 of *Collected Works of Georges Florovsky* (Belmont, Mass.: Nordland Publishing, 1976), p. 108.
4. For this point, I owe a debt of gratitude to William F. May. See May 1987, esp. pp. 181–82.
5. I have drawn in this analysis from Jaroslav Pelikan’s extraordinary book, *The Shape of Death* (1961). See esp. chap. 5.
6. See May 1987:181 for a powerful discussion of this misuse of theology.

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Figure 1. *Death Recognized as a Friend*. Lithograph by Käthe Kollwitz, 1934.

Collection of the National Gallery of Art, Washington. Rosenwald Collection. © 1993 ARS, New York/VG Bild-Kunst, Bonn.

The Visual Arts in Medical Education

Mary G. Winkler

Art as a helper in times of trouble, as a means of understanding the conditions of human existence and of facing the frightening aspects of those conditions, as the creation of a meaningful order . . . these most welcome aids are grasped by people in distress and used by the healers who come to their assistance.

—Rudolf Arnheim, *To the Rescue of Art: Twenty-Six Essays*

The purpose of art is to lay bare the questions which have been hidden by the answers.

—James Baldwin

THE CONNECTION OF THE VISUAL ARTS with ethics may not seem obvious. Since Plato we have been given to understand that art is nothing but the appearance of appearances. For those willing to embrace irreality there is an alternate view: art is pleasing, a frill. It's nice when we have the leisure to enjoy it, it's even "enriching," but it's not "practical"—it's too removed from practical uses. How does one apply something so subjective, so ethereal to the study and practices of medicine? What place does it have in medical education?

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"Art," wrote psychologist of art Rudolf Arnheim, "is the most radical attempt to understand the meaning of our existence" (1986:148). "The meaning of existence" is a weighty phrase, one that encompasses human needs for understanding our place in the universe and our condition as sentient and mortal. From the attempt to find meaning arise questions about suffering and death, along with reflections on the inability of our dazzling intellectual powers to bring final certitude. The drive to find meaning leads us to formulate ethical systems and to define relational situations in ethical terms. Behind "ought" and "should" answers are questions of meaning. Therefore, as a "radical attempt to understand the meaning of our existence," art plays a role in moral thought. In this role art may be of use in helping students think about ethical issues.

The visual arts belong in a medical ethics curriculum for several reasons.¹ First, most medical students have grown up within a media culture. As young adults in a society permeated with visual images and stimuli, these students are already adept at reading the visual language of television commercials, photo journalism, billboard advertisements, MTV, and film. When they begin their training in medicine, they will be taught to interpret the images created by an increasingly sophisticated technology. Using the visual arts to open discussion on ethics is thus planting seeds in fertile ground.

Second, in analyzing a complex work of art, students hone observational skills. Looking at art gives the viewer practice in seeing and acknowledging nuances and multiple interpretations. Philosopher John Gilmour observes that "great works of art exhibit an overdetermination of meaning; they tend to create multiple associations, which raise puzzling questions for a thoughtful viewer" (1986:13). He finds likeness between the artist and the philosopher, noting that art, like philosophy, makes us reflective about our opinions. That reflection, he asserts, may help us to avoid thoughtless utterances, and a reflection that makes our opinions stand in relief against clearly formulated alternatives can show us where our presuppositions lie. Thus works of art, like carefully constructed arguments, can shake our prejudices to their foundations.

Third, art revels in ambiguity. Medical ethics can gain from art's ability to expose either/or formulations that lead to pat answers and intellectual stalemates. Art has the power to give new perspectives, to provide safe entrée to the shadowy, the unexpected, the emotionally dangerous. In addressing the unruly, the grotesque, the anarchic, and the painful in a structured, disciplined way, art provides the viewer a means of contemplating dangerous subjects from a safe distance.

Art historian and theologian Doug Adams (1991) asserts that art has the power to expose the fallacy of mistaking the parts for the whole. This brings us to the fourth reason for using art. Great art makes us see individuals, not concepts or

stereotypes; we are helped to see the situation from the inside, "as a situation with a human being in it" (Kuspit 1989:257). Moreover, because art teaches us that there is something other than ourselves, it leads us to view our relationships with others in a new light.

Fifth, art requires a balance between reason and sensibility, intellect and "body knowledge." Hence the study of art can overturn false boundaries of the kind that frequently prevent holistic conceptions of understanding and care. In other words, art unites all aspects of our humanity, making feeling and cognition interchangeable.

Finally, the visual arts open the mind's eye to the richness, complexity, and beauty of the world and its inhabitants. In *Serious Art*, philosopher John Passmore (1991) offers an extended response to Plato's rebuke that art lovers ("the lovers of sights and sounds") remain at a retarded, sensory level of moral development. Passmore's response is pertinent to a discussion of art and the training of ethical behavior. To enjoy the world and to hate its degradation is, he asserts, a moral act. "The love of what lies around us and the art which brings out its sensory quality is not just an ornamental sentiment. It has a moral character." Art redeems by directing our attention to little things, to a world whose complexity and beauty are worth seeing and celebrating. Artists, he argues, act as guardians of the particular and the individual; celebrating variety and particularity, they perform virtuous acts. Passmore maintains that adherence to abstractions rather than enjoyment of the particulars of the sensory world leads to vice, to prejudice, to views that discount or demean (1991:156–57).

This, then, is the rationale for including the visual arts in a course on the values and ethics of medicine. What follows is a description of how art has been integrated into such a course for first-year medical students at the University of Texas Medical Branch.² The students are instructed in small groups by the faculty of the Institute for the Medical Humanities, nine scholars representing history, literature, philosophy, theology, visual studies, and



Figure 2. *The State Hospital* (detail). Mixed media by Edward Kienholz, 1966.

Moderna Museet, National Swedish Art Museums, Stockholm. © Edward Kienholz. Photo © Statens Konstmuseer.



Figure 3. *Puberty*. Painting by Edvard Munch, 1894.

National Gallery, Oslo, Norway. Photo: Scala/Art Resource, New York.

law. Since all instructors use the same syllabus, the use of visuals is tailored for scholars who may not have extensive training in art but whose individual disciplines make them practiced in analysis and interpretation.

One class session early in the fall term is devoted to the visual arts. Each teacher leads his or her class in a discussion of 10–12 slides: discussion begins with the open-ended and neutral question, “What do you see?” I am responsible for providing a range of artworks that treat such subjects as death, pain, aging, fear, bureaucratic indifference, and poverty. In general, I seek works that are subtle, ambiguous, and challenging, but also accessible to an untrained viewer. Thus most works are from the Western tradition and are representational. Moreover, although many famous works of art deal with medicine and medical practice, I tend to choose works that are not directly about medicine. Rather, I look for works that reinforce the idea of our common humanity and the vulnerability that we all share.

One of the most effective artists for this purpose is Käthe Kollwitz (Figure 1). Kollwitz’s lithograph series on death, as well her portraits of her aged husband “waiting for the call of death,” open discussions about attitudes toward old age, death, euthanasia. Because Kollwitz, a physician’s wife, based many of her works on her observations of her husband’s impoverished patients, her socially conscious studies of poverty, hunger, and fear are aids to compassionate thinking about the homeless and the indigent as well.

Burned Face, a disturbing canvas by the Dutch artist Karel Appel has also been an important work for our course. The painting powerfully portrays physical pain, and it works well as part of our discussion of patient autonomy (we frequently use the story of Dax Cowart, who in his horrible suffering from burns demanded the right to die). Some colleagues use photographs of hospital scenes taken by John R. Glowczwski, a photographer at the University of Texas Medical Branch. Other works about patients in hospitals are Edward Kienholz’s

Birthday, a tableau of pain and loneliness, and *The State Hospital* (Figure 2), an angry work that indicts bureaucratic cruelty and speaks about the anguish of the suffering and the forgotten. Both works of art are reminders of how suffering feels from the inside.

None of these works is “easy,” but none should confuse the students or shame them into silence if they lack formal training in art. All of these, and more, have proved effective for discussion—sometimes in novel and unexpected ways. Recently, one of my students related *Burned Face* to anatomical dissection. His observation that the painting reminded him of what his class was doing in anatomy lab led to a discussion of how the class *felt* about dissecting a fellow human being. In this case, the broaching of a taboo subject was serendipitous.

We may, however, *choose* to bring difficult and embarrassing topics to the discussion table. We know that students expect to encounter *thanatos* in their studies. Death and dying are prominent in many contemporary ethical issues, and we bring them before students many times.

Eros is another matter. Yet some very serious issues in medicine have to do with sexuality: gender roles, abortion, teenage pregnancy and birth control, AIDS. How we respond to these issues reveals our fundamental stance toward our own sexuality and that of others. Medical students are in many ways vulnerable. Many are young enough to be still adjusting themselves to a sexual identity. Many bring stereotypical notions that are uninformed or even prejudiced. Our culture is highly eroticized (one need only glance through any women’s magazine or watch any beer commercial to confirm this assertion), yet little in medical education helps students examine their own presuppositions and anxieties about their patients’ sexuality—or their own. As I think about the uses of art in medical education, I become ever more convinced that the visual arts are a very effective means for undermining prejudice and stereotypical thinking, for allaying anxiety, and for increasing understanding responses to sexuality.

Any number of rich and evocative examples could be cited here, but I would like to discuss only

one: Edvard Munch's *Puberty*, painted in 1894 (Figure 3). Here, a young girl sits naked on the edge of her bed. Her hands are crossed awkwardly and rest tensely on her lap. Behind her a dark, formless shadow hovers. Is it her fear of her incipient womanhood? Is it a protective emanation? Or is it sexual, phallic? Everything in the picture suggests dis-ease, vulnerability, even a kind of anxious wonder. Her tense frontal posture makes the role of the viewer ambiguous. We are not welcome to her in her solitude, yet she is prepared to receive our gaze. In response to the question, "What do you see?" one male student replied, "It makes me think about coming to examine a patient." Other responses relate to recent memories of the students' own uncertainties during adolescence and to their anxieties about seeing female patients.

Increasingly important is the subject of AIDS and the problem of homophobia, prejudice, and fear. The number of artworks on this issue is growing daily. Many of the photographs of AIDS patients in *Epitaphs for the Living*, by Bill Howard, are extremely conducive to eye-opening discussion. The book presents a series of photographs of patients accompanied by their observations about their illness in their own handwriting. The format invites a direct encounter and an intimacy with patients that is quite unusual. I also like to juxtapose two other works: Robert Mapplethorpe's famous/notorious frontal self-portrait and Rembrandt's *Return of the Prodigal Son* (Figure 4). Many students recognize Mapplethorpe's self-portrait because it has frequently illustrated news accounts of recent censorship controversies. The young photographer faces his camera nude from the waist down. He is wearing lipstick and mascara, and his hair is long and worn in an androgynous style. His confrontation with the viewer troubles many students. Sometimes it rouses disgust or anger. One colleague reported that a student demanded, "Why do we have to look at *that*?"

Another colleague wondered whether we were confirming stereotypes by showing this portrait. My reply had two parts: first, I reminded him that it was Mapplethorpe's *own* decision to offer himself to the

viewer this way. By staring directly into the camera (that is, into the viewer's eyes), he demands that we see him in all the ambiguity of his self-created androgynous pose. He dares us to see through the stereotypical presentation to a deeper ambiguity and uncertainty. Second, I quoted an observation made by an older female student who had looked at the slide: "The picture seems to say, 'This is as hard for me as it is for you.'" She grasped, I think, the essential message: all of us must deal with our own uncertainty, our own demons. And young physicians must learn to welcome all patients with gentleness and compassion.

Compassion and all-forgiving love emanate from Rembrandt's retelling of Jesus' parable of the return of a lost child. A meditation on forgiveness and redemption, the painting creates, in art historian Kenneth Clark's words, "a feeling of compassion so intense it has the power of healing" (quoted in Halewood 1982:62). Rembrandt composed the scene so that the viewer enters at the moment of the father's and son's embrace. The viewer is thus included in the reconciliation and in the peace. As a graduate student observed, "We [the viewers] are next in line for a hug."

Seeing the self-portrait and the painting together may awaken awareness that at some time we are all "prodigals"—and that we may also embrace the role of the gracious parent. A very great work like Rembrandt's transcends specific issues and leads us to reflect on our common vulnerabilities and longings—and can lead us to mercy.

If one can see wonder, self-doubt, and vulnerability in *Puberty* or in Mapplethorpe's self-portrait, one can find them also in two self-portraits of artists' aging bodies. Edvard Munch and Alice Neel each expose themselves to our gaze (Figures 5, 6). Munch's self-portrait, done after he was 70, has analogies with his study of puberty. In the painting he sits on the floor completely naked; his aged flesh, sagging belly, and grizzled beard are the objects of his own contemplation. The squint (often a hallmark of a self-portrait) expresses both the artist's invasive scrutiny and the aging man's bewildered self-



Figure 4. *The Return of the Prodigal Son*. Oil on canvas by Rembrandt van Rijn, 1665.

Collection of the Hermitage Museum, St. Petersburg. Photo: Giraudon/Art Resource, New York.

knowledge: "This, then, is who I have become." Munch must surely have recognized the irony of posing his old man's body in the place of the classical male nude, for centuries Western art's final statement about human potentiality. Alice Neel's self-portrait is bold, an affront to sensibilities accustomed to taut and youthful flesh. She poses as a nude—and as an artist. It is an unflinching yet sympathetic self-appraisal, and as such it must call into question presuppositions about the naked female body and about beauty.

After thinking about the "sorts and conditions" of human beings depicted, I return to the student's question, "Why do we have to look at *that*?" The answer emerges clearly for me: Because these examples of our humanity will be your patients. It is these people you meet when you see patients. If you can see them with the penetration, objectivity, and love of an artist, you will have learned much about the ethical practice of medicine.

If you use your imagination, as the artist does, to see your way beyond surface appearances, you step

into a new reality. Imagination is the key. To quote James Conlon: "Imagination is grounded in and depends on some negation of reality, some refusal to accept the present, an entertainment of possibilities over actualities." This imaginative quality, Conlon concludes, is a precondition to change, and "Conscious change depends upon a refusal to let things alone, an inability to feel at home with the way things are" (1990:104).

In seeing patients you will be confronted with poverty, ignorance, ugliness, meanness, mortality—questions and problems that cannot be answered or solved with a biomedical education alone. Here, art and artful thinking help, by opening the mind to imaginative understanding.

I began with the words of Rudolf Arnheim, and his words also provide a fitting conclusion: "True contemplation is essentially active. . . . Faced with the pregnant sight of reality, the truly creative person does not move away from it but toward it and into it" (1986:298). It is the ability to move into the "pregnant sight of reality" that art can teach. ☉

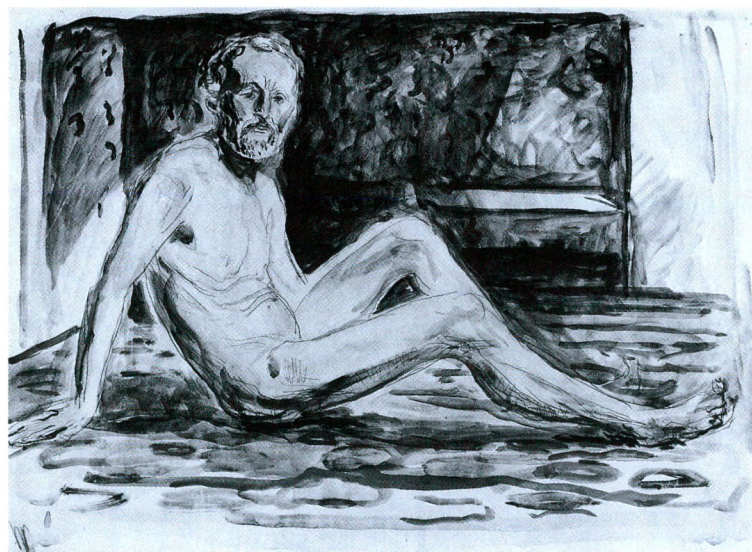


Figure 5. *Autoportrait en nu assi* (Self Portrait). Painting by Edvard Munch, 1934.

Munch Museum, Oslo, Norway. Photo: Scala/Art Resource, New York.



Figure 6. *Self Portrait*. Oil on canvas by Alice Neel, 1980.

Collection of the National Portrait Gallery, Washington. Photo courtesy of Robert Miller Gallery, New York.
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NOTES

1. Throughout this essay when I use the words *medical education*, I do not aim to be exclusive. I believe that my thesis holds true for the education of any health care worker. My own experience, however, is with medical students, and I am discussing work that has been done with them at my institution.
2. The course director is Harold Y. Vanderpool. I am grateful for his discussions on the history and philosophy of our medical ethics course and for his support of my experiments using the visual arts.

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“We are terribly ignorant.
We should be anxious to learn,
to experiment, to discover a
little more about God.
We should listen to anybody
who thinks he knows
something about God.
More than a billion dollars a day
are spent on scientific research.
If one-tenth of that were spent
on research in spiritual subjects,
that would be a hundred
million dollars a day.
That would be visionary.”



Bridging Two Worlds

An Interview with Sir John Templeton

The mysteries of human personality are deep, not easily explored or explained. What special set of talents leads someone who first was interested in ministry and missionary work to go into the world of finance, indeed of high finance, there to excel? And what leads such a person, after having become a success in that world, to put energies into science and theology, fields normally outside the scope of business enterprisers?

Such questions come to mind when one deals with a world-renowned “builder of bridges” between scientists and theologians, between science and theology. They came to mind during our interview with Sir John Templeton at his home in the Bahamas, where he received *Second Opinion* editor Martin E. Marty and the Park Ridge Center’s president, Laurence J. O’Connell.

That Sir John has endowed a Templeton Prize for progress in religion has made his name familiar to many who otherwise would not know of his interests. That he has helped establish agencies like the Center for Humility Theology—a title whose meanings he always has to explain, and does here, too—is less well known. But *Second Opinion* and its readers, always interested in the juncture of science and theology, have good reason to explore the interests of this pioneer. We found him to be not someone who claims expertise in the specialties of science or theology but instead someone who has respect for those who work at the frontiers of both—and who wants them to interact as they often have not done.

Second Opinion: In your own earlier writings and in those of people you’ve encouraged, “science and theology” usually meant cosmology or astrophysics, the furthest-away things, the biggest things. Now we see an interest in the genome and genetics, the closest things, the littlest things. Are these in any contradiction? How do you account for your own move without abandoning your early work?

Templeton: We never started out to study science and religion. We started out to encourage progress in religion, all types of religion. We hoped that religion would become just as progressive as medicine or astronomy. For at least 40 years I have thought that religion should be just as exciting as any other field. But throughout history most religions have been uninterested in new concepts. Most religious people have felt

that they knew it all already and that anybody who disagreed with them was wrong. I am trying gradually to persuade different organizations and people that religion should be forward-looking and should admit that no human being has ever known one percent of the infinity of God. We are terribly ignorant. We should be anxious to learn, to experiment, to discover a little more about God. We should listen to

anybody who thinks he knows something about God. Probably in the long run the manpower and money we invest in discovering more about God should approach what goes into science. More than a billion dollars a day are spent on scientific research. If one-tenth of that were spent on research in spiritual subjects, that would be a hundred million dollars a day. That would be visionary.

I've been a trustee of Princeton Seminary for 40 years. They don't appropriate anything for research in the same sense that a hospital or a medical school would. The research in the Princeton budget is for archeology and ancient scriptures, which is nice. But it doesn't really lead us to know a lot more about God in the end. Since I couldn't find any organization concentrating on progress in religion, I've undertaken that. I may not succeed. It may not be feasible for anybody, but that's what I'm focusing on. The first step, 21 years ago, was to offer prizes for progress in religion. The progress has come in different fields, and out of the 23 winners so far, 5 have been in *science* and religion.

I hope that we can do research on many subjects in science and religion. We can't hope to foresee where God will reveal himself. Bob Herrmann and I published a book called *The God Who Would Be Known*, with the idea that God

is ready to reveal himself if we search with humility and in the right way. It never occurred to me to wonder *where* we should search—whether in astronomy or genetics or prayer or love. Almost no research has been done on love from a scientific standpoint, on its origin, nature, varieties, encouragement, or results. We are trying one thing after another to encourage people to do something that increases our knowledge of God, God's purposes, or God's love. Maybe 10 percent of the ideas we try will work. With that humble approach, it really never occurred to me to search, say, in astronomy and not in genetics.

Second Opinion: Your writings express a certain buoyancy—only one-half of one line suggests “I may not succeed.” What's cheered you most during these 40 years? Where is the progress occurring? What has made you say, “Here's where I think we will leave a mark”?

Templeton: I guess that would be in science and religion. I thought a long time ago that there were many people working in science and religion who didn't know what other people were doing or even that other people were working in the field. We published a *Who's Who in Science and Religion*, and it seems to have been a great help. We discovered 70 organizations in that field and roughly a thousand people. We're starting a second edition in which we'll be able to list far more. That encourages me.

Second Opinion: You mentioned that none of the great religions seems truly willing to experiment with openness. Yet if you look at their history, they were born doing two things: they pointed to the new, and they brought the holistic view that you are describing, which includes health. What happened to religions long ago that led them to stop being experimental and venturesome?

Templeton: They didn't stop, because they never began. The main restraining influence has been and is personal ego—the concept that we are the center. For countless ages human beings thought that the earth was flat, because it *looks* flat. For countless ages humans thought that the sun revolved around the earth, because it *looks* that way. For countless ages people have thought that their god was the only true God. The Jews were not the only ones to think they were the chosen people. And the human ego has in effect said that God is understandable. Human ego has led most religions—I'm talking about forgotten religions—to say that they had the whole truth, they knew the mysteries. Now astronomy has defeated human ego—we no longer think we are very important in a hundred billion galaxies. I would like to see that happen in our knowledge of God. I don't think we know much more about God now than we knew about the hundred billion galaxies 2,000 years ago.

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Second Opinion: Your colleague once wrote an essay I couldn't help noticing—"On Taking Vows in Two Priesthoods"—I'm going to assume that's science and religion. What is it about those two that brings out this version of ego? I don't mean ego the way a rock star has ego. I'm talking about premature closing off of thirst for more knowledge. Why does it happen in these two areas where there is the most to learn?

Templeton: I don't think it has happened in science. I believe science is open-minded. Scientists do argue with each other about which one is right, but still, almost every scientist will agree that they know so little and they need to learn. In religion, perhaps it happened because the high priest and the dictator were often the same person, and to maintain order he had to say, "This is it" (and probably convinced himself of that).

Second Opinion: Let's not let science off the hook so easily. The theory of science says there is always more to learn, and you've hung out with the kind of scientists who are self-critical, but very often science closes off the voice of religion. Isn't that ego also?

Templeton: Yes, it is. In the nineteenth century, perhaps many scientists thought that they had the truth, and it was not necessary to go beyond what was visible. Now I think most scientists would agree that what's visible

"If science is free to do the extreme experiments, the ones that are useless or harmful will quickly die out and be forgotten. The few that are useful will flower."



has no reality—that reality is deeper than the visible or the tangible. We are about to publish a book called *Evidence of Purpose*. Each of 12 famous scientists has written a chapter on his science and what in his science would indicate that the creation of human beings, who are so filled with purpose, couldn't have been by chance. That's one of many illustrations. In general, scientists have been willing to say, "This is the explanation as of now, but let's continue to spend even more and more money to find better explanations."

Second Opinion: What will it take to get organized religion going this way?

Templeton: The Center for Humility Theology has assembled what we call our board of advisors—29 distinguished people—to help us answer that very question, and we are learning what we can do to get it going. First we tried offering the world's largest prize, and I think that helped. We collected all the information about people working in the field, and I think that's helped. I think the Gifford lectures (the Gifford Lectureship in Natural Theology, begun at the four ancient Scottish universities in 1888), going back two centuries, have helped. We've copied them in a format that allows greater frequency. We run five programs of lectures at least twice a year. So lectures by theologians and scientists are another method.

We are now trying to publish a bibliography of research by natural scientists on spiritual subjects. People say, "Sure, you can do research in chemistry, but how can you do research in spirituality?" At least a hundred people have done research in spirituality. We are now setting up a program to help locate financing for any expert who has a serious research project. Many of these programs probably will look wrong or at least ineffective 10 or 20 years from now, but those are our attempts to get organized religion going.

Second Opinion: There's a sunny side to your thought, but there's a dark side to reality. A hundred and fifty years ago evolution scared people. What frightens you about scientific inquiry or subject matter or knowledge? I don't mean weapons research or something like that, but is there anything frightening in the nature of reality as you face it?

Templeton: Let me give you two opposite answers: on the one hand, I'm a great believer in competition. If science is free to do the extreme experiments, the ones that are useless or harmful will quickly die out and be forgotten. The few that are useful will flower. On the other hand, I do worry about human nature, which seems to welcome hearing about bad things. If you are passing a newspaper stand and one paper says nobody did anything bad yesterday and another one says 12 coeds were raped on campus,

"The people who welcome certainty tend to go into churches, and the people who welcome uncertainty go somewhere else."



which newspaper do you buy? That's not the fault of the publishers or the television people—to be successful they have to cater to that human characteristic. And I don't see how that's going to be changed. A hundred years ago there was so little communication that this peculiarity of human nature wasn't very harmful. But now people are just flooded and influenced by evil things. It's so extreme that I would say the character and the pattern of thought, the human personality, is now mainly established by television.

Second Opinion: I would like to move back a step. I've heard you describe the theology of humility, which I also would characterize as a theology of awe of creation. Looking at your remarks from *Is Your God Big Enough?* I wonder if it would be fair to say that your fundamental concern is with our ability to open ourselves to revelation about God.

Templeton: I would agree with your hypothesis if we are talking about organized religion but not if we're talking about spirituality. It's egotistical to think we can comprehend total reality. It's also egotistical for us to think that we are the final product of God's creative process. In these hundred billion other stars in our galaxy and hundred billion other galaxies God may be manifesting himself in something beyond our comprehension. Take that plant in the corner: It might be aware of me—

sometimes I water it, sometimes I touch it. The air it breathes is the air I breathe and so forth. So that plant may have some knowledge of me, but it's a tiny bit of knowledge. In the same way maybe God is right here too, and maybe I have a tiny knowledge of God, but it's very tiny.

Throughout history humans have tended to think that religion was an aspect of life. But just the opposite may be true: life may be an aspect of religion. Humans have tended to think that God can be proven to exist or not exist and that God is separate from humans. But more and more the evidence is the other way around—that God is the totality of which each of us and all humanity together is a tiny little part. The simile I've used and like best of all is the ocean (although similes don't stand up, as you know, to careful examination). The waves on the ocean are made up of molecules that make up the water, and they form into waves, and the waves have a beginning and an end and an effect. Civilization is like a wave on the ocean. And you are like a molecule in that wave of civilization. But the ocean is God. When the wave is gone, the ocean is still there, and there will be more waves. When your molecule is gone, it isn't gone permanently; it's simply in another situation. I won't carry it as far as reincarnation, but that is the concept: the human body is not eternal, but the human soul may be. Just as the atom in the ocean is not used up when a wave subsides, maybe

humans are not used up when their bodies die or their civilizations die.

Second Opinion: I still have the feeling in this conversation that we are letting science off a little too easily. Its definition is humble, but its practice is not. Churches have built hospitals and have built universities and colleges with science departments, but we don't expect acceptance to come from the other direction. Could one say perhaps that religion is more open to the word of science than science is open to the word of religion?

Templeton: Yes. But again, in assembling our board of advisors, we have found the scientists to be more helpful than the theologians.

Second Opinion: More helpful because they are more open to the "not yet known"?

Templeton: Yes. There are, of course, open-minded theologians. Still, by the time you've got a doctor's degree in theology you've committed yourself to some historic principles. It isn't so easy for a person who has finished his Ph.D. in theology to say "I don't know much and feel awfully ignorant."

Second Opinion: This relates to what the Park Ridge Center is trying to do in our work on the Human Genome Project. We are trying to help prevent the clash

between religion and science in the area of genetics. Our project is concerned with the potential impact of organized religion on public policy relating to the genome project. The Human Genome Project will allow us to do wonderful things, but that same knowledge can lead to great human injustice. We can know which fetus is going to have heart attacks and so on. The value religious people place on the gene, on human consciousness, may lead some people in science to say, "You've projected a philosophy onto our work that might limit our work." In the area of genetics, science may be more threatened by religion than religion is threatened by science.

Templeton: I don't disagree with that, but I wouldn't have approached it in that way. I would say that the evidence is building that scientific research, including the genome project, is part of God revealing himself, and that God has always been ready to reveal himself, and that he reveals himself to those who seek. If we seek, we will learn more about the purposes or the reality or the infinity of God than we would have imagined before. For example, a century ago, you couldn't have convinced anybody that hundreds of neutrinos are going through your body or passing right through the earth. Now we believe there are. I don't think scientific research has harmed religion in the sense that it has held religion back. But some people in

religion fear change. Still, I would not say it's because of religion; it's because of egotism. Religious people who say, "You're in danger of turning loose on humanity some horrible germ" are fearful of change because they don't understand it. Some of them also are receptive to fixed ideas—many people welcome certainty and hate uncertainty. The people who welcome certainty tend to go into churches, and the people who welcome uncertainty go somewhere else.

Second Opinion: I'm involved in a five-year project studying fundamentalisms around the world. Hundreds of millions of people are turning to these very hard-line, unscientific religions. Is that just egotism again?

Templeton: Yes, in my opinion. For example, communism was a great drawback to the people in Russia, but some people were very happy with it because they didn't have any uncertainty. They knew they had a job, they knew what their status was—everything was fixed. There were no new problems, no new methods. They liked that.

Second Opinion: But in order to achieve progress we do have to make people uncomfortable and restless first. For two years I've been part of a program called "Fourth Tuesdays." Some 20 Chicago-area M.D.s who are doing Ph.D.s in religion, ethics, science, get together and present

papers to each other. These people are open to religion, open to science. If you were there for an afternoon, what would be your main message?

Templeton: We're just *beginning* to have knowledge about God and God's purposes, so I would give a talk on the need for progress in religion.

Second Opinion: A lot of people have trouble with the word *progress*. What is your understanding of *progress*? What would progress look like in religion and the human body, religion and human consciousness, religion and spirituality? From what to what?

Templeton: Progress comes in unexpected ways. Progress comes by competition as much as anything else. Progress comes from a few people trying to do it better. I like the saying attributed to Edison: "If there is anything you are doing the way you were doing it 20 years ago, then there is now a better way." But I think I can come closer to your question in saying that two centuries ago 85 percent of the people in America and Europe were farmers, because they had to be in order to feed the country. Now only about 3 percent of Americans are farmers, but we don't worry about food shortages; we worry about surpluses. Now that's progress in agriculture. Two centuries ago they were worried about not having enough whale oil. Then

they began to use coal. After coal, they discovered petroleum. As recently as 20 years ago the Club of Rome got together all these famous people, and they published books that said the world was going to run out of energy. But they didn't take into account that new methods of energy, such as nuclear energy, would be infinite. I couldn't have told you two centuries ago there was going to be petroleum or coal or nuclear energy, but these discoveries happen. And that's my attitude toward what we try to do in discovering God, or discovering the nature of God through his creations. Who knows? If we just try hard enough, even though 99 things we try will be useless, one thing will be wonderful.

Second Opinion: If we go back to humility theology, then, for you progress is the surprise that occurs if you're wondering enough and inquiring enough?

Templeton: Not just wondering; taking action on it.

Second Opinion: People in the eighteenth century thought you could program progress—you could write the encyclopedia and then everyone would progress and there would be more freedom and equality. This is not your progress. Your progress is open-mindedness, or what might be discovered?

Templeton: And free competition.

Second Opinion: Can we play with that word a little bit now? Each word has an underside. *Competition* isn't a dirty word, but there's a theological downside; if there's competition, there are losers. You can't have progress without somebody advancing and somebody being left behind.

Templeton: It's a very widespread concept among Christian ministers that a person gets ahead economically by pushing other people down. When I was at Oxford 57 years ago, the majority of the teachers, maybe even the majority of the students, were socialists, and I had the longest, most extreme arguments with them on this subject. They argued that competition—free enterprise—was helping the rich and harming the poor. They were thoroughly convinced that I was lacking in compassion and that I didn't want to help the poor. But my viewpoint is that I was the one who was trying to help the poor; I wasn't trying to divide the pie, I was trying to multiply the pies. I argued with these people, and I don't think I ever won an argument. Well, I'm just overwhelmingly grateful I lived long enough to see communism collapse—I finally won the argument! Now none of those people that I argued with 57 years ago could argue the way they did then.

In my lifetime the standard of living worldwide has quadrupled. And in history it took a thousand years or more just to double the standard of living. But the speed

“The speed of prosperity is increasing so greatly that our studies here in investment indicate that the world's standard of living will double in only 20 years and double again 20 years after that. That's because of competition and free enterprise.”



of prosperity is increasing so greatly that our studies here in investment indicate that the world's standard of living will double in only 20 years and double again 20 years after that. That's because of competition and free enterprise; some parts of the world were still free to have new ideas—they were not regimented. Regimentation is the opposite of what I am working on. I'm working on having religions recognize the drawback of regimentation. Regimentation has been the *bane* of religions. Why are the mainline churches dwindling? Partly because they can't get away from the concept of doing it the same way their grandfathers did it. The churches that are growing are new.

Second Opinion: A moment ago you were talking about quadrupling the world's standard of living. Again, in a half-line you've noted one of the deterrents to further progress, the problem of overpopulation. You'll toss out something like that and not pursue it. You would rather enable people to think about it. You don't go up to the Pope and say you've got your own policy. So you choose not to be the one who's stirring things up on birth control but stirring people to think it through.

Templeton: That's correct. Because I don't know what the policy should be. I just say that you should be open-minded and experiment and see what's beneficial.

Second Opinion: So your being an “enabler” is a choice of vocation: a Christian calling, a religious calling, a spiritual calling? How did you know that you might do that? Do you wake up some days and say, This is what I’m in the mood for?

Templeton: In a way, yes. I think most human beings go through life not really knowing what their calling is. Some of us stumble into one thing, and then we find we’re in the wrong place and change it. Many of our students at Princeton Seminary previously had another career. I didn’t know that I was right, and young people in general don’t know they’re right. I always gave it a lot of thought. I thought at one time that the highest calling was to be a Christian minister. I watched the Christian ministers and decided that was not my talent—others were doing it better. I thought about being a missionary, and again the same thing happened. I decided that the best I could hope for in a spiritual way was to be a missionary’s helper. When I was 18 I came to believe that the talents that God had given me—not many and not so different from other people’s—were elements of judgment and foresight. Where would they be useful? In reading the newspaper I could see the prices of shares fluctuate an average of 100 percent a year. People were losing their money by investing in some company at a time of optimism and paying too high a price. They didn’t know it

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was too high a price because they hadn’t taken the time to find out what the company was worth in the first place. So I undertook at 18 to educate myself on judging the value of corporations. I thought that would help people and would help religion in the sense that if I were good at it I would be able to do things like what I’m doing now. When I became a trustee of Princeton Seminary their endowments were \$3 million. Now they are \$450 million. Of that, \$35 million is just new gifts not spent on buildings, and the rest is profits. So I hope that in some ways I am being a missionary’s helper.

Second Opinion: No matter how comfortable we can make things—we can relieve a lot of suffering—there is still dying. People suffer. One of our concerns is to find new ways to address human suffering, because all the progress in science isn’t going to make us immortal. You’ve had some bad luck along the way, the death of your first wife, for example. We all have these things happen. How do you face life’s terrible setbacks? What are your resources?

Templeton: It goes back to humility. I don’t know what God wants me to do. I don’t know why good fortune has come to me more often than bad fortune. I do believe that chance favors the prepared, as it’s been said. Opportunity knocks on the door of those people who prepare thoroughly.

All the shelves of books written on the problem of evil have explained almost nothing of God's purposes, but I believe this earth is created by somebody far wiser than I and that there's probably some purpose in the things that happened to me and the even sadder things that happen to other people. I doubt if I'll ever understand why it is, but I don't have any trouble believing that the one who created the earth is doing it the right way.

Second Opinion: Does character figure into your understanding of God's plans? Take, for example, little children, who have a whole life ahead of them. They have to make something of their lives, and they are going to stumble on things. Do you have anything to say to them?

Templeton: I don't know what to say to children until they are able to reason. When a child is able to think logically and forwardly, then one great need is that schools teach the basic principles that lead to usefulness and happiness. It's far more important, I think, for a child to learn basic spiritual principles than it is to learn Latin or even civics. One of our major projects is to compile a list of those principles, or laws of life, that should prove helpful as one proceeds along the road to spiritual maturity. I hope when it's published that we can get schools, outside America mainly, to use it as a textbook.

Second Opinion: Let's skip to college level then. I noticed that you tend to support smaller colleges, often historically church-related or liberal arts or private. Is there something about the nature of smaller institutions that makes possible development of character? If so, is there something we in society should be doing differently? Organized religions get big and they get ossified. Is there something about size?

Templeton: Family is a good influence on a child, and a larger family is a good influence on a child, but when it gets so large that he doesn't know the other people, you lose that. Edward S. Harkness had that idea, so he donated to Yale University an enormous amount of money, and it was all used to break up the university into colleges of no more than 200 students. I'm old-fashioned enough to believe that fraternities are one of the best educational institutions in colleges because you learn from the brothers in the community more than you learn in the classroom. It may be that the best ethical training, the best character training is done in places that are not too big for the child to know everybody he meets during the day.

Second Opinion: Mark Seigler of the Center for Clinical Ethics at the University of Chicago stresses the importance of the character of decision makers in medical ethics issues. He says when the issue comes down to whether you "pull

the plug," you don't call in the philosophers from the university. You ask, "What does my *good* doctor think? What does my *good* pastor think? What does my *good* family think?" As you mentioned just now, you've put energies into the colleges of character, which is Aristotle's way of doing ethics. How does that fit into your view of the bigger projects? What do health and medicine need in the line of ethics that the focus on character will give?

Templeton: A huge amount! The problems in ethics and medicine are multiplying very rapidly as you know. The chief rabbi in the United Kingdom and the dominions—Rabbi Jakobovits—won the Templeton prize not because he's the chief rabbi but because of his work in medical ethics. And we are the investment managers for most of the assets of the Canadian Medical Association, so we are helping them to publish a worldwide magazine called *Humane Medicine*, which focuses entirely on ethics and medicine. But there are so many questions, and nobody knows the answers. So I'm sort of humble about that. I think we should try to find the answers, but I don't believe we are going to find them. We continue to face not only big questions in medical ethics but more and more questions in medical ethics. I hope we solve them, but I don't see it happening. One of the projects we were working on yesterday is to help locate funding sources for research on

spiritual subjects. We hope to be an information center so that a person who wanted to do research could come to us for advice on how to pursue funds available through other sources, including individuals and foundations.

Second Opinion: Our main energy in ethics is not to ask, What additional thing can a religious person say that the philosophers haven't thought of? Our questions are "What does it mean to care for a person through 30 years of Alzheimer's, what does it mean to care for people with AIDS, what does it mean to give hospice care?" I would say that religious ethics plays its biggest part there.

We're trying to construct an approach to medical ethics that does justice to the fullness and depth of human experience, and to the inescapable divine dimensions of human experience. We're trying to develop an approach that can be helpful but doesn't pretend to have all the answers. That isn't simplistic. I think that's very much in line with your theology of humility and your notion of progress in religion. I think people are confused about your intent. They think religions.

Templeton: Oh, yes. Almost every person on our board of advisors to the Center for Humility Theology has started out by saying "You have to change that name; nobody understands it." But we don't want to change the name. We want people to understand it. I even think that maybe

"Regimentation is the opposite of what I am working on. I'm working on having religions recognize the drawback of regimentation. Regimentation has been the *bane* of religions."



Teilhard de Chardin was lacking in humility when he said that civilization was going to reach an omega point. I think it's egotistical to think this little planet with this little civilization is going to be the termination of God's ongoing purpose. In all probability there is no omega point. There is no termination. We don't know that either. But it's a human tendency to think we are more important than we are. When Teilhard was writing, he assumed that human beings as we now exist were the ultimate of God's creations. And I think that's very egotistical. It's very unlikely that we are the ultimate development. We are just somewhere along the line of progressive development.

Second Opinion: In terms of your own understanding of Jesus Christ incarnate, why would God have chosen to become incarnate now, at this point in the developmental phase? If we are going to have progress, could there be another incarnation at the next level?

Templeton: Yes. Most people believe in a second coming. Hindus say that. I like the old saying that you learn about God from two books—one is the Bible, and the other is the book of nature. My life work has been to advance the conversation and cooperation between the people who respond to these two books. ☸

REFLECTION

Forty-seven Years after Hiroshima: An Office Visit

Tom Welsh and David J. Elpern

Dermatology clinic notes 4/28/92

Tom Welsh, a light-skinned 68-year-old man, grew up in Ohio, was in the Pacific theater during World War II, and spent the postwar years as a self-employed painting contractor in southern California. Retired to Kauai a few years ago. He was in Hiroshima after the bomb was dropped and has concerns that radiation exposure there may have caused some skin cancers. The skin examination was unremarkable save for a 4 mm in diameter pearly papule on the left lower back. It had the typical appearance of a basal cell carcinoma, and was shave excised, curetted, and desiccated. The specimen was sent for pathology. I reassured Mr. Welsh that this lesion posed no threat to his well-being and was unlikely to have been caused by his time in Hiroshima. I'll call with the biopsy results. Suggest follow-up visit in six months.

David Elpern, M.D.

Tom Welsh's notes—dermatology visit

Tuesday, April 28, 2:00 p.m.

I know he will find cancer. That's the way my mind works; always thinking the worst. Then, if you are able to walk out of the place, you will feel lucky. So I tell him I always got sunburned and peeled at least two or three times every summer as a kid growing up

in Ohio. Oh, and by the way, I was in Hiroshima about six weeks after they dropped the bomb.

That's also the way my mind works. When in a sweat about something, always tell about a worse thing to put it in perspective.

Then he says, "What about Hiroshima?" So I tell him.

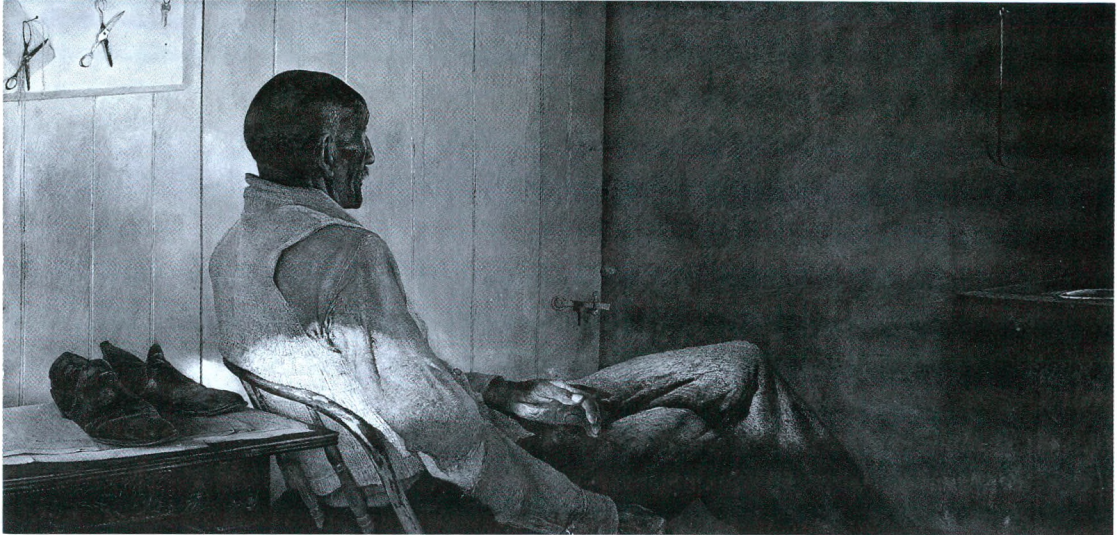
I was a merchant seaman during World War II. In August 1945, I had just paid off a ship that had gone to India by way of Australia and ended up in New York—all the way around in just two months and 22 days. I'd ridden a train across the country and landed in L.A. the day we dropped the bomb. I couldn't wait to go to Japan. I had to see what we had been going after so hard and for so long. So I went down to San Pedro and asked for the first ship out—anything that was going straight to Japan.

We carried invasion cargo bound for Yokohama. But when we got there, they didn't need it. After a couple more stops we ended up in a place called Hiro, a small port not far from Hiroshima.

Two shipmates, Dewey and Jimmy, and I hitched a ride on an army truck and went as far as we could go. Hiroshima was off-limits to military personnel; but we weren't military, we were merchant sailors. So we walked the rest of the way into what had been the city of Hiroshima.

It was burned flat. But there was a tall building still standing in the center. We were told it was the city hall. It had been designed by American engineers to withstand earthquakes. Once inside, we walked up the steel stairway. The steps were covered with a fine white powder that looked like flour. It was plaster turned to dust. We left footprints everywhere we walked.

*Tom Welsh is a retired painting contractor. He lives in Hanalei, Hawaii.
David J. Elpern is a physician with the Kauai Medical Group, Lihue, Hawaii.*



That Gentleman. Tempera on panel by Andrew Wyeth, 1960.

Collection of the Dallas Museum of Art. Dallas Art Association purchase.

The glass from the windows was melted over the sills. I saw a bottle that had melted straight down so the top was in the center of a large puddle of solid glass. It was the remains of a tall saki bottle.

We looked out an opening where a large window had been. We could see over the whole city. Tree trunks stuck up like charcoal sticks; no limbs, just black pointed poles. Nothing moved. No wind. No birds. No bugs. It was spooky. I thought, "This was one hot bomb." We'd never seen bomb damage like this before. No large piles of rubble; just ashes.

Every small business in Hiroshima must have had a safe. When the buildings went up in smoke, the safes went straight down into the basements. Since there were only ashes down there, the safes were easy to see. We picked out a large one and went to work on it with the small tools we carried. You have to know that most merchant seamen looked like survivors from a shipwreck. We wore army jackets and boots, navy sweaters, and marine pants. We liked the pants be-

cause they had large pockets—good for the tools we carried and the junk we collected.

We were real pack rats. Dewey liked electronic parts. He could build a radio out of almost anything. I saved name plates with foreign writing. The safe we were working on had a beautiful plate with Japanese characters and coins that had been cast in brass.

We three were down this hole—Dewey playing with the dial, Jimmy working the handles, and me unscrewing the plate. We were laughing and making cracks about how neat it would be if the safe would open and be full of gold coins or diamonds or something.

I looked up and saw a bunch of people standing around the top of the hole. We were down around eight feet. They were watching us without a sound. I put my head down and told the other guys not to look up. Man! If I was up there and you guys were down here I would stone you to death and cover you with rocks!

We decided to brass it out, make it all a big joke, and slowly get the hell out of there. So we smiled and waved at the people and said "Hi, how are you?" They looked at us like we were crazy. We kept on smiling and waving and slowly climbing out of that hole. It was weird. They began to smile and wave back a little. Once out, we slowly walked away, all the time thinking that at any minute they would start throwing rocks.

By this time it was getting dark, and a light rain was falling. All I could think about was how those people looked. Jimmy said, "Did you see the guy with one eye and one ear gone and no hair on one side of his head? That must have been the side that faced the bomb." Dewey said, "What about the woman with the skin all gone from one arm and the side of her head?" My God! Those people were a mess. But none made a sound, none uttered a word.

After a while we knew we wouldn't make it back to the ship that night. We met a kid on the road. He looked about 10 or 12 years old and was watching us

as we walked along. The kid could speak a little English, so we asked him if he knew a place where we could spend the night. He said to follow him.

We walked behind him for quite a way until we came to a hole in the ground covered with a piece of old corrugated metal. We were wet and cold and stood there looking at this hole he called home. The kid said, "I am sorry, B-29." We said we were sorry too and walked away.

For 16 years I didn't think about that kid and the hole he called home. Then one day I told an old lady I was working for about it, and I really fell apart.

That's what I remember best about that damn war. I saw lots of real bad messes;

but the thing I'll never forget is the look of that kid and him saying he was sorry.

Oh, yeah, the doctor found a real little skin cancer halfway down my back and removed it in about two minutes. See! I told you my system worked.

P.S. I think the doc knew I was scared and talked a lot to hide it.

**Tree trunks stuck up like
charcoal sticks; no limbs, just
black pointed poles.
Nothing moved. No wind.
No birds. No bugs.
It was spooky.**

ISSUES & CURRENTS

Physician-Assisted Suicide: Putting the Cart before the Horse

Ron Hamel

The push toward the legalization of assisted death continues and, in fact, despite the November 1992 defeat of Proposition 161 in California and the March 1993 outlawing of physician-assisted suicide in Michigan, it appears to be gaining ground. Practices once abhorrent to most health care professionals are gradually coming to be seen by many as part of a continuum of options for comfort care for the terminally ill. More and more discussions of the subject in the literature, at conferences, and in the media appear to be at least sympathetic to, and in many instances clearly supportive of, the practice of assisted death. There are some indications that several religious denominations may modify their opposition to assisted suicide and euthanasia in the next few years. And the conversations one hears among the general public seem increasingly to be receptive to this development.

One indication of the shift in attitudes toward legalization of assisted death is the publication of two articles in the November 5, 1992, issue of the prestigious *New England Journal of Medicine*. In "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide," Drs. Timothy Quill, Christine Cassel, and Diane Meier propose the acceptance of physician-assisted suicide (but not euthanasia) and seven criteria for its clinical implementation for competent, terminally ill patients for whom all other alternatives have failed. Physician-assisted suicide is advanced as a last resort on a continuum of options for the care of the terminally ill. The authors write:

We strongly advocate intensive, unrestrained care intended to provide comfort for all incurably ill persons. When properly applied, such comfort care should result in a tolerable death, with symptoms relatively well controlled for most patients. Physician-assisted suicide should never be contemplated as a substitute for comprehensive comfort care or for working with patients to resolve the physical, personal, and social challenges posed by the process of dying. (1380)

What the authors don't address is how to achieve better palliative care. A proposal is made for the acceptance and institutionalization of physician-assisted death, the *last* option on a continuum of palliative care, when many, if not most, health care institutions are notoriously poor at providing far less drastic alternatives and prior options. This is puzzling. What has been and is being done to promote the acceptance and "institutionalization" of better comfort care? While Quill, Cassel, and Meier speak of physician-assisted suicide as occurring in the rare case, it is likely to occur more frequently if *it* is available and adequate comfort care is not.

In a companion article, "Assisted Death—A Compassionate Response to a Medical Failure," Howard Brody argues for a compromise position between directly prohibiting physician-assisted suicide and establishing it as standard policy. He suggests viewing physician-assisted suicide "as a compassionate response to one sort of medical failure." It would be used only in those "few cases" in which "medical failure" occurred. Death itself should not be construed as medical failure; only a "bad death" resulting from "the ravages of disease or ill-constructed medical interventions" should be so construed (1992: 1383–85).

A "good death," in contrast, should be considered a medical success story and should serve as a standard. "Medicine produces a good death when it uses life-prolonging interventions as long as they produce a reasonable quality of life and a reasonable level of function (defined in terms of the patient's own life goals) and when it then employs the highest quality of hospice-style terminal care" (1992:1385). In describing a good death, Brody makes a critical observation. He notes that the call for assisted death on the part of 55–65 percent of the public

seems based in large part on the fear that physicians will . . . either overtreat them with life-prolonging technology long after a return of meaningful function is impossible or abandon them when they need control of symptoms and emotional support. It is moral cowardice and social unresponsiveness on the part of the medical profession not to state in the strongest possible terms that either overtreatment or abandonment in these circumstances is inappropriate care. Therefore, a good death . . . proclaims a standard that, if it had the confidence of the public, would presumably reduce the demand for assisted death by a substantial degree. . . .

Those on both sides of the debate over assisted death can agree that all patients should be confident that physicians will aid them with the latest palliative care to relieve terminal suffering and will respect their right to refuse life-prolonging treatment and to execute advance health care directives. One hopes that this view, if fully and effectively implemented, would considerably reduce the number of patients who will request a physician's aid in dying. . . . Unfortunately, far too many American physicians still think that neglect of symptom control and a "never say die" attitude in the face of worsening illness constitute good medical care. That these instead constitute inappropriate medical practice is a position that must be argued vigorously if the American public is ever to regain the trust in physicians' compassion that we have all too nearly lost. (1992: 1385, 1387–88)

Brody is right in his identification of a very serious problem. But he is a bit too sanguine about the possibility of the public's regaining trust in physi-

cians' compassion. Patients are not confident that physicians will offer them the latest in palliative care or will respect their advance directive or their right to refuse life-sustaining treatment. This has been and continues to be the problem. Much work needs to be done before the public alters its perception of how dying occurs in American health care institutions. We are a long way from "fully and effectively implementing" what Brody considers to be a good death. Until we do, medical failure will not be a rarity nor will physician-assisted suicide be an "exceptional response to medical failure."

To refer to assisted death as a response to medical failure "is to make the strong claim that assisting a death is an admission of incompetent medical practice until proved otherwise" (1992:1386). Incompetent practice would consist in failure to explore various ways to relieve suffering and in failure to assure that the patient was making a capable, informed, and rational decision. In either case, a defense of assisted death would fail. When these conditions are met, however, and can be defended before a review panel, Brody proposes that prosecutors not seek an indictment. In addition, Brody calls for intraprofessional review. Physicians who assist in a patient's death should be called on to defend their actions against the sharpest questioning of their peers in an open forum.

Despite Brody's attempts to limit and control physician-assisted death, the very factors that make it an attractive option remain ultimately unaddressed and unresolved in his proposals. Unless current medical practice undergoes a radical change, "good deaths" will be a rarity and "medical failures" rather common. If physicians are honest, they will likely have a difficult time defending physician-assisted deaths. Their patients may well be capable of making an informed and rational decision, but it is questionable whether they will be able to offer a full range of options for palliative care.

A recent study reported in the January issue of the *American Journal of Public Health* (Solomon et al. 1993) stands in stark contrast to the ideal standard of a good death proposed by Brody and would seem to confirm the claim that with the exception of hospices our health care institutions generally do not do well in providing care for the terminally ill. The study surveyed 687 physicians and 759 nurses in five hospitals located in Massachusetts, Georgia, California, and

Washington, D.C. One was a city hospital, another a Catholic community hospital, and three were urban teaching facilities. The study had two goals: first, to find out how health care professionals assess the care of patients near the end of life; second, to learn whether physicians and nurses are aware of and in agreement with national recommendations regarding patients' rights to forgo life-sustaining treatment and to receive adequate pain control.

The results are troubling, though not entirely surprising. Respondents reported considerable dissatisfaction with the way patients at their institutions were involved in treatment decisions. Only 36 percent were satisfied that patients in their institutions were informed about different care alternatives (medical attendings 49 percent, house staff 43 percent, nurses 25 percent). Only 31 percent overall thought that staff took sufficient care to find out what critically and terminally ill patients wanted (medical attendings 40 percent, house staff 27 percent, and nurses 26 percent), and only 29 percent were satisfied that patients' wishes were entered in the medical record (medical attendings 37 percent, house staff 37 percent, and nurses 21 percent). At the same time, 87 percent overall agreed that "all competent patients, even if they are not considered terminally ill, have the right to refuse life support even if that refusal may lead to death" (medical attendings 86 percent, house staff 87 percent, nurses 98 percent).

The extent of dissatisfaction with patient involvement in decision making is underscored by providers' concerns about the appropriateness of care provided. Forty-seven percent of respondents agreed that they had acted against their conscience in providing care to the terminally ill (medical attendings 38 percent, house staff 70 percent, and nurses 50 percent). The preponderance of these violations of conscience involved overtreatment. Fifty-five percent of respondents felt treatments were overly burdensome (medical attendings 58 percent, house staff 78 percent, and nurses 51 percent), while only 12 percent agreed that they gave up on patients too soon (medical attendings 15 percent, house staff 8 percent, and nurses 12 percent). In other words, four times as many health professionals were concerned about overtreatment as about undertreatment. Respondents expressed concern most often about the inappropriate use of mechanical ventilation (overall 67 percent,

medical attendings 60 percent, house staff 78 percent, and nurses 66 percent); cardiopulmonary resuscitation (overall 64 percent, medical attendings 61 percent, house staff 83 percent, and nurses 69 percent), artificial nutrition and hydration (overall 54 percent, medical attendings 55 percent, house staff 52 percent, and nurses 54 percent), and dialysis (overall 51 percent, medical attendings 42 percent, house staff 53 percent, and nurses 50 percent).

Perhaps most troubling are the responses relating to pain control. Eighty-seven percent agreed that it was possible "to prevent dying patients from feeling much pain" (medical attendings 89 percent, house staff 91 percent, and nurses 86 percent). However, in response to the statement that "the most common form of narcotic abuse in the care of the dying is undertreatment of pain," 81 percent agreed (medical attendings 85 percent, house staff 84 percent, and nurses 78 percent).

According to the investigators, "this research establishes that health care professionals are themselves deeply concerned about the provision of inappropriate, overly burdensome care to patients near the end of life and about inadequate participation by patients in decision making about treatment" (Solomon et al. 1993:19). They also recognize the inadequacy of pain relief. Despite all the talk about advance directives and a national consensus about forgoing life-sustaining treatment articulated in widely publicized guidelines and policy statements, a wide gap between theory and practice in end-of-life decisions remains. Can physician-assisted death be seriously proposed as a "last resort" while that gap continues to exist? In theory there may be a broad continuum of options for care of the terminally ill, but in practice that continuum is truncated. In this case, physician-assisted suicide is not truly a last resort.

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NOTEBOOK

At St. Patrick Hospital in Missoula, Montana, Therese Schroeder-Sheker plays the harp and sings to dying patients to help them "move toward completion and to unbind [them] from impediments to a tranquil passage." She describes her bedside work, for which she receives no fee, as "musical-sacramental-midwifery, the reconciliation of art and science for recovering the dignity, reverence, and tenderness within the personal experience of death." Her work,



known as "music thanatology," is changing how dying patients are cared for in some hospitals and hospices.

Schroeder-Sheker is founder and director of the Chalice of Repose Project, the only program in the world known to train music thanatologists. The project is supported by seven institutions that help promote health care methods based on mind-body principles. She became interested in the connection between music and death while working part time as an aide in a nursing home. "I had witnessed a number of deaths there that were quiet, cold, unprepared, isolated, statistical events, and this was very troubling," she said. "I realized I could do something. I could hold their hands, sing to them. I could show up and not leave them alone to die with 'I Love Lucy' blaring on the TV."

(Stephen Foehr, *Chicago Tribune*, 7 March 1993)

Because community mental health services are underfunded and poorly coordinated, people with psychiatric disorders or chemical dependencies are showing up at local emergency rooms with increasing frequency.

"The general emergency department is not really equipped to provide ongoing psychiatric services," said Edward Hannin, M.D., associate chairman of the department of psychiatry at St. Vincent's Hospital and Medical Center, New York City. "Imagine someone having trouble coping with reality coming into the emergency department for care among all of the other acute patients. The safety net has developed larger holes and the mentally ill are falling through the cracks. Unless their needs are addressed, they are not going to be cared for under any system."

(*American Hospital Association News*, 15 March 1993)

A new Gallup Poll surveying religious attitudes around the world finds that only 4 percent of Americans describe themselves as atheists or agnostics. And even that number is high compared to percentages the poll reports from most of the other 18 countries in the survey.

Great Britain and Bolivia matched the United States with 4 percent. South Korea and Portugal had 3 percent; Nigeria, Canada, and Finland, 2 percent. Among the countries with fewer than 1 percent atheists and agnostics were India, Turkey, and Ireland.

But in Uruguay, 1 out of every 10 people is an atheist or an agnostic. Uruguay's consul general in

New York, Julio Tealdi, said he was not surprised that his country had topped the nonbeliever list. Uruguay, which is largely Roman Catholic, has a long tradition of separation of church and state, he said. European immigrants who came to Uruguay, unlike those who



came to the United States, tended to be those who were persecuted for being nonbelievers rather than those holding differing religious beliefs.

Of the 96 percent of Americans who said they were believers, 82 percent said they were Christians (56 percent Protestant, 25 percent Roman Catholic, 1 percent Eastern Orthodox), and 2 percent said they were Jewish. All other faiths accounted for less than 1 percent each.

(*New York Times*, 27 February 1993)

Jack Wennberg of the Dartmouth Medical School says doctors often don't know what treatments work or which treatments best serve their patients. That helps to explain why certain surgeries are performed much more frequently in some cities than in others, even when there is no showing of systematic benefit from the surgery.

The remedy is simple but expensive: to conduct exhaustive studies of outcomes to sort out which treatments work and which don't. But sometimes there is more than one sensible response to a problem. For example, a prostate condition common to older men causes a frequent and uncomfortable need to urinate. The problem can be treated with surgery, but it can also be treated without surgery if the patient is willing to live with discomfort. Such surgery, though it relieves symptoms, does not in general prolong life. And mishaps can occur, leading to, for example, impotence. So which treatment is best?

Wennberg proposes "shared decision making," which depends on patients' receiving full, impartial

information. He and Dartmouth colleagues have prepared videotapes that set out the likely benefits and possible costs of different treatments. Doctors who favor each treatment are shown, as are patients who have chosen each treatment.

At a Kaiser HMO in Denver, men who viewed the video and talked to their surgeon chose surgery only half as often as patients advised only by their surgeon. Dr. Wennberg estimates that if the entire U.S. health care system needed as few urologists per patient as Kaiser-Denver now needs, the nation could stop training new urologists for 18 years.

(Michael M. Weinstein, *New York Times*, 13 December 1992)

The American Medical Association for Health Policy Research reports that the number of patients physicians see per hour decreased significantly between 1983 and 1991. This means that the time physicians spend with patients increased, with primary-care physicians spending the most time with patients.

(*American Medical News*, 14 December 1992)

Physicians attending a symposium at the Massachusetts Institute of Technology last fall learned how pollution harms health. The meeting, sponsored by



MIT and Physicians for Social Responsibility, dealt with such issues as how to measure and deal with local pollution problems and the need for a public health view in confronting the worldwide environmental crisis.

A recurring theme at the conference was that physicians—for a variety of reasons, including denial, apathy, and a lack of formal training in environmental

and occupational medicine—have neglected the environmental debate, even as scientific evidence mounts that pollution is a growing health menace. Studies show that pollution of all kinds kills more than 2 million people worldwide each year.

(*American Medical News*, 26 October 1992)



According to a growing body of social scientific evidence, children in families disrupted by divorce and out-of-wedlock birth are six times as likely to be poor and to stay poor longer: 22 percent of children in one-parent families will experience poverty during childhood for seven years or more, as compared with only 2 percent of children in two-parent families. Children in single-parent families are two to three times as likely as children in two-parent families to have emotional and behavioral problems. They are also more likely to drop out of high school, to get pregnant as teenagers, to abuse drugs, and to be in trouble with the law. They also are at a much higher risk for physical or sexual abuse. Many have a harder time achieving intimacy in a relationship, forming a stable marriage, or even holding a steady job.

(Barbara Dafoe Whitehead, *Atlantic Monthly*, April 1993)



The case of Karen Ann Quinlan, a 21-year-old who lapsed into an irreversible coma following an accident (and who survived 10 years in that coma), launched unprecedented changes in case law, legislation, and medical ethics decision making affecting what came to be known as “the right to die.” Similar tragedies befell other families: 25-year-old Nancy Ellen Jobs was left in a permanent vegetative state following an anesthesia accident, and Nancy Beth Cruzan, also 25, was left in a permanent vegetative state by a car accident. In a recent issue of *Trends in Health Care, Law & Ethics* honoring Karen Ann Quinlan, the families of the above three women described their experiences in their own words.

While Karen remained in the Morris View Nursing Home, visiting her every day for ten years became our way of life. As a family we were under tremendous stress. There were days when

I could not mention Karen’s name at the dinner table because our son, John, would leave the room. He was only 17 at the time. There were days when I could not speak what was in my heart in Joe’s presence for he was not facing reality. With his strong faith, he thought that God would perform a miracle and bring his daughter back. There were times when I was full of fear and wondered if our lives would never return to normal. We lived in a state of limbo. What happened, of course, affected our other two children’s lives. Mary Ellen was a music major at Centenary College in Hackettstown and when she received her bachelor’s degree, she thought she would teach piano to normal children. But she said, “I can’t do that now, Mom. I’ve seen too much suffering.” She went on to receive a Masters Degree from Loyola in music therapy and she’s worked with retarded adults, retarded children in a psychiatric ward of a hospital, and she’s now working with geriatric patients. Mary Ellen and John have grown to be beautiful and loving young people and we’re very proud of them. . . .

Somehow, through God’s help, our family crossed a threshold into a world where life has a deeper meaning. I cannot share my experiences without sharing my faith. Through prayer, the Lord gave me the strength not only to accept, but to cope with the day-to-day heartbreak of those ten years.

—Julia Quinlan (mother of Karen Ann Quinlan)

[Nancy] was moved to a nursing home. Her physical appearance deteriorated. Her muscles contracted despite many prosthetic devices. Her gums grew over her teeth. She developed terrible acne and, except for her lovely ponytail, she was unrecognizable as our beautiful Nancy. Even harder to accept was her mindlessness. A very bright, independent, loving human being was reduced to an empty shell with only some reflex action from the brain stem. I was always aware of one of these reflexes—a silent scream. Only when the doctors helped me understand her brain couldn’t feel pain as ours does, could I stand it.

Nancy’s nursing care was excellent. When her nose got too sore, a feeding tube was inserted in her stomach with a 24-hour pump. Later

when that broke down, a tube was inserted in her small intestine. No one could ever convince me that was food and feeding, that is, love and comfort; it was a mechanical device.

Well, time went on and John, our son in law, Bob, and I finally accepted the hopelessness of her condition. Many things were occurring in our lives, including John's malpractice suit, births, deaths, and other illnesses. So it was about four years before the three of us were able to discuss the futility of prolonging a non-life life. Each of us was afraid to dash the hopes of the others and my husband was the last one to concede that there was no life for Nancy. Finally, I did several things. I consulted with our pastor for the position of our Presbyterian Church, and was assured by him that since life is eternal, there is no need to artificially maintain it when there is no quality to it. I consulted a counselor to help me deal with all my fears and, at her suggestion, found a doctor who could help me understand how painless death could be for Nancy.

—Eleanor Laird (mother of Nancy Ellen Jobs)

The people in the hospice unit had given me a little book that described death, three months out, three weeks out, the last few hours. One of the descriptions was what they call "fish out of water" breathing—a kind of gasping. Around 2:30 AM on the morning of the 26th, Nancy began to do this. We were with her. I was holding her head, my wife was near me and Chris was on the other side of the bed. At 2:47 AM Nancy took her last breath. I reached down and closed her eyes and Nancy was finally at peace. It was an eerie feeling. During the last thirty minutes or so, there were some tears, but not very many. It was like we were cheering her on: "You've come this far and all you have to do is stop breathing and you're free." And at 2:47AM, December 26, 1990, Nancy was finally free!

People who have followed the case probably have heard of the right-to-life protesters who came to the hospital. . . . On December 24, they put up a sign that said, "Nancy's Gift at Christmas from her Parents and Doctors—Death."

After Nancy's death, I had to stay at the hospital to draft a statement making an announcement of Nancy's death. While I was waiting, I jotted this down, "Today as the protesters'

sign says, we give Nancy the gift of death, an unconditional death that sets her free from this twisted body that no longer serves her, a gift I know she will treasure above all others, the gift of freedom. So run free, Nan, we'll catch up later."

—Joe Cruzan (father of Nancy Beth Cruzan)
(*Trends in Health Care, Law & Ethics*, Winter 1993)

Last year's unsuccessful campaign for the legalization of euthanasia in Washington State revealed that patients and their families fear a protracted and painful death. This led the Washington State Medical Association to publish a clinical guide to pain management. *Pain Management and Care of the Terminal Patient* includes information compiled by oncologists and anesthesiologists on pain and symptom management, drug therapies, hospice care, treatment for patients with HIV, and suggestions for managing pain in the elderly.

(*American Medical News*, 14 December 1992)

Dr. Ken Dychtwald, a recognized authority on aging, maintains that American culture has a strong fear of aging, gerontophobia. He lists the six most pervasive myths about aging:

1. *People over 65 are old.* There are no biological or physiological reasons to link age 65 to the onset of old age.
2. *Most older people are in poor health.* They may have long-term, controlled health problems, but older people are not always limited by them.
3. *Older minds are not as bright as younger minds.* Diminishment in mental ability happens to the very old and is due to other factors such as drug interactions.



4. *Older people are unproductive.* History tells us of those who were productive well into their later years: Between age 71 and 89 Michelangelo supervised the creation of St. Peter's Basilica in Rome. On his seventieth birthday, Jack Lalanne swam 1.5 miles across Long Beach Harbor, hand-cuffed and shackled, pulling boats full of friends and reporters. When he finished, his pulse was 76.

5. *Older people are unattractive and sexless.* For many elderly couples, sex and romance can and do continue into later years.

6. *All older people are pretty much the same.* There is no other age group more diverse in physical ability, personal styles, tastes, and desires.

(*Lutheran Witness*, January 1993)

Eight years after crack hit New York and other big cities around the country and concern about a generation of "crack babies" began spreading, medical experts say their worst fears are not being realized: while up to a third of such children appear to have been seriously damaged, 20 to 40 percent seem unscathed. Those who have been harmed benefit from therapy and other special attention, and many fully recover.

Unfortunately, only a small fraction of affected children are receiving the simple therapeutic procedures needed. Dr. Ira J. Chasnoff, president of the National Association for Perinatal Addiction Research and Education, estimates that of the 300,000 or more children who have been damaged by cocaine or other drug exposure, no more than 10 percent have received treatment, leaving the problems of most of the children to be discovered when they turn up in kindergarten or the first grade.

(*New York Times*, 16 February 1993)

By the end of 1995, maternal deaths caused by AIDS will have orphaned approximately 24,600 children and 21,000 adolescents. The overall number of motherless children will exceed 80,000 by the year 2000 unless the course of the AIDS epidemic changes dramatically. Most of these children will come from poor communities of color.

(*Journal of the American Medical Association*, 23/30 December 1992)

A survey of 1,400 doctors and nurses at five major hospitals from various parts of the country found that nearly half the attending physicians and nurses and 70 percent of resident physicians act against their conscience in overtreating terminally ill patients, even when there is no chance of recovery and death is considered imminent. The results of the survey suggest that patients' wishes are often ignored and that ignoring them may be contributing to the escalation of health care costs. Eighty-one percent of respondents agreed that the most common form of narcotic abuse in caring for the dying is undertreatment of pain.

(*New York Times*, 14 January 1993)

Women live longer than men, but many will live their "golden years" in poverty. According to a recent report by a House select subcommittee on aging, by 2020, almost half of the elderly women living alone will be struggling to live on incomes of less than \$9,500 in 1993 dollars. Because both Social Security and pension plans are structured in a way that penalizes women for getting divorced and for taking time off to care for children, women are 70 percent more likely than men to spend retirement in poverty.

(*World Traveller* [Northwest Airlines], 11 February 1993)

A Christians-only wing at the county jail has sparked controversy among inmates, attorneys, and local officials in Fort Worth, Texas. The Chaplain's Education Pod, known to inmates as the God Pod, features religious videos, hymn sings, Bible instruction, and what one nonbelieving convict referred to as "a cushier lifestyle." Local officials insist that the inmates there have no greater privileges than elsewhere in the jail, except for being allowed to play a secondhand organ donated by a local church. But some former prisoners have protested, including a Jewish inmate who objected to the concept and a Methodist who contended he was removed from the 48-cell unit and transferred to a dingier wing because his beliefs conflicted with the fundamentalist beliefs encouraged in the unit.

Jail officials said they could not understand the interest that attorneys and civil liberties groups have taken in the cell block, stressing that participation in the block is voluntary. Van Thompson, assistant district attorney for Fort Worth, acknowledged that only Christians lived in the pod, adding that county officials would probably have no philosophical objection if someone proposed a separate pod for people of other



religious beliefs. "Half the black guys in there are Muslims," he said. "Nobody's come forward to do it though. Certainly there would be a good case for accommodating it." He also said that he doubted there would be a need for a Jewish pod. "Quite frankly, we rarely see a Jewish inmate in our jail. They either get bailed out right away, or they just don't come in."

(Sam Howe Verhovek, *New York Times*, 11 February 1993)

Many African Americans living with HIV or AIDS lack access to health care, and many others who do have access are not receiving care that meets their physical, emotional, and spiritual needs. A work group of AIDS experts and advocates sponsored by the Bureau of Health and Resources Department recently identified these barriers to improving care and services:

- Other issues—for example, discrimination, poverty, fair housing—divert attention from HIV-related issues.
- Many African Americans distrust whites and believe the AIDS epidemic is part of a genocidal conspiracy.
- Many people do not know they are infected. Of those who do, many are not aware of the local, state, and federal services that are available, and too often the help that is available is not accessible.

- Staff of health care organizations may be poorly informed about HIV. Others are insensitive to factors such as poverty, illiteracy, language barriers, sexual orientation, and gender. There is a shortage of black health care providers.
- Some women may delay seeking treatment because caring for their family takes priority over caring for themselves, and child care is seldom available. Women with HIV may fear that their children will be taken away because of their diagnosis.

(HRSA [Health Resources and Services Administration] *Highlights*, 2 March 1993)

A two-year Yale University study on the distribution of clean needles to drug addicts concludes that returned needles testing positive for the AIDS virus have dropped from 68 percent to 41 percent; more addicts are trading in needles more frequently, which suggests that they are sharing needles less; the rate of new HIV infections has decreased approximately 33 percent. Despite similar hopeful results in Holland, Sweden, and other countries, most needle exchange programs remain illegal in the U.S.

(*U.S. News & World Report*, 29 March 1993)

An advisory subcommittee to the National Vaccine Program maintains that "the provision of free vaccines to all infants and children would be an admirable statement of our commitment to children's health. [But] it is an oversimplification to believe that this measure alone would solve our problems." This subcommittee suggests a user-friendly system encouraging participation; a common registration system to track immunizations given; education programs for parents and employers on risks and benefits of immunization; and insurance coverage for immunizations and for well-baby and well-child programs.

(*Journal of the American Medical Association*, 24/31 March 1993)

Only 4,548 people in the United States donated organs in 1992, an increase of 18 people from 1991.

Lorraine Willmot of the Regional Organ Bank of Illinois notes that two obstacles to organ donation are that families often do not know the wishes of the deceased relative and that many people believe that their religion opposes organ donation. According to Willmot, no major Western religion opposes organ donations.

(*American Medical News*, 22/29 March 1993)



In reaction to the lawsuit filed by the ACLU against Michigan's new ban on assisted suicide, an official of the U.S. Catholic bishops' prolife secretariat warned the elderly and seriously ill that legal efforts to assure their right to assisted suicide "will not advance their freedom but cheapen their lives." Richard Doerflinger, associate director for policy development in the bishops' Secretariat for Pro-Life Activities, said the ACLU arguments promote "the euthanasia agenda in its most extreme form."

"By invoking a 'right to privacy' like the one used 20 years ago to legalize abortion, the ACLU also invites analogies to a policy of unlimited abortion that has claimed 29 million unborn lives," Doerflinger said. "Ironically," he added, "while the ACLU supports abortion on the grounds that the victim is a non-person with no rights, it supports euthanasia on the grounds that the victim is a person with a basic right—a right to be killed."

(*New Catholic Explorer*, 19 March 1993)



Rabbi Stephen Shulman is frequently asked by patients and families at the hospital where he is chaplain, "What congregation are you with?"

"I tell them that this is my congregation—the patients, family, staff members here at Memorial Sloan-Kettering Cancer Center," says Shulman. As the number of seminary graduates increases and the number of pulpit positions declines, young rabbis are moving toward alternatives in academia, Jewish agencies, and in pastoral work as hospital, military, and prison chaplains. With the advent of new ethical dilemmas in the medical field, such as physician-assisted suicide and AIDS and the issues of sexuality that often surround it, the field of health-related pas-

toral care has come to be very much on the cutting edge of contemporary Jewish theology.

Rabbi Shulman and other rabbinic chaplains at Sloan-Kettering say they draw extensively not only upon *halachic* learning but also upon their backgrounds in clinical pastoral education (CPE), a form of interfaith, experiential training that encourages pastors to bring aspects of their own lives into their ministry. One CPE exercise involves meditating on one's own death, including how it would affect family members and friends, to prepare for the circumstances of the death of a patient.

"I think a lot of young people are looking for more authenticity than they feel they can find in the pulpit rabbinate," says Rabbi Kestenbaum, who held an Orthodox pulpit in Pennsylvania for nine years. "The pulpit rabbinate is filled with glitz, but often, I think, they're missing the interpersonal relationships."

(*Forward*, 19 March 1993)



Duke University doctors found that a hospital's practice of reviving patients whose hearts stop beating costs more than \$150,000 per survivor. Of 146 patients given CPR after suffering a cardiac arrest, 84 patients, or 58 percent, were revived, but only 7 patients, or 5 percent, got well enough to leave the hospital; most never regained the ability to breathe on their own and spent their final days in intensive care units, often running up high bills. The total cost of saving the 84 patients was \$1.1 million. When the cost is distributed among those who went on to lead meaningful lives for a period, it was \$150,000 for each of the 7.

(*New York Times*, 21 March 1993)



Caring for a parent is often fraught with stress. The demands of caregiving increase as the aging children's abilities to meet these demands decrease. Reports of abuse, financial problems, tension, negative effects on the mental and physical health of caregivers, and interference with career advancement and care of children abound.

Sons tend to become caregivers only in the absence of an available female sibling. These sons rely on the

support of their own spouses, who provide much of the care. Men provide less overall assistance to parents than do women and, not surprisingly, perceive such responsibilities as less stressful than do their female counterparts.

Parents' moving into the homes of their adult child may alleviate or increase stress. "I'm glad my mom's here. I worried about her living alone, perhaps falling and breaking a hip and unable to get help," said one 61-year-old daughter. "It's easier for me with ma here," said a 56-year-old son. "I had to run over there three times a week to do errands, mow her lawn, fix things." "I feel safe here, knowing I'm not alone at night," said a 76-year-old parent.

However, as demands on time, space, and energy increase, the level of stress goes up. Busy adult children spend extra time shopping and doing errands. "My time is not my own any more," said a daughter. Another woman reported, "My mother-in-law expects me to come right home from work and fix her supper. She makes me feel guilty if I want to go out to dinner." A son-in-law said, "Every Saturday it's running around with her mother—go to the hairdresser, take

her to the drugstore, visit the cemetery. It's easier to go to work. I'm not hounded as much." Space is an issue for many families because teenagers and grandparents may long for privacy. Teenagers ex-



pressed a variety of feelings about having grandparents living with them: "It's ok I guess, she just sits in her room and watches TV." "It's kind of a drag, she's always here whenever I want to have friends over." "She usually puts in a good word for me with my mom when we fight, and gives me money. That makes my mother crazy."

(Janice Thibodeau, *Nursing Outlook*,
January/February 1993)

LITERATURE DIGEST

Voluntary death in the Jaina community

Purushottama Bilimoria, "A Report from India: The Jaina Ethic of Voluntary Death," *Bioethics* 6 (1992): 331-55.

The experience of the Jaina community in India of dealing with impending death presents an interesting contrast to the argument in American society over the morality of assisted suicide and active euthanasia. Because death is seen not as the end of life but as simply a transition to another stage, Indians have long contemplated notions about the ideal death and the most noble way of dying. In this article, Bilimoria examines the Jaina view of voluntary death, describing the community's reflections on the bioethical implications of this practice as well as the constitutional issues raised in legal deliberations on the fundamental rights of the individual to life and to death in Indian society.

Commensurate with their deep regard for all forms of life, the Jainas are committed to the virtue of noninjury (*ahimsa*), adopted and popularized by Mahatma Gandhi as the principle of nonviolence. This principle notwithstanding, the Jainas permit a member of the community, under certain circumstances, to end his or her own life—"to actively welcome impending death in a nonviolent manner." From the Jaina point of view there is no real paradox in affirming absolute nonviolence against any form of life yet also claiming the right to terminate one's own life under certain circumstances in the act of "voluntarily-embraced death" (*santhara*). The founder of Jainism, Mahavira, is said to have voluntarily starved himself

to death through a fast, gradually withdrawing from physical appetite in a process of increasing meditation, acting to relieve his community of any responsibility it might feel toward his care. This, according to Jaina wisdom, is the correct attitude toward death and a proper way to die.

Santhara typically involves an extended fast: "abstaining indefinitely from taking food until death arrives." The goal of this terminal fast, or *sallekhana*, is a peaceful passing away of the encumbrances of a physical reality in a yogic or "enlightened" death. Actions that cause injury, undue harm, pain, or prolonged suffering are ruled out by the guiding principle of *ahimsa*. For Jainas, fasting to death is one option for bringing an end to suffering and, incidentally, hastening the liberation from the physical realm by dispelling one's action-effects (*karma*) in favor of rebirth into a higher life.

Jainas claim that *sallekhana* has ethical justification on the grounds that one is not obligated to prolong his or her suffering in the face of imminent or impending death. Several conditions serve to restrict or eliminate whimsical adoption or abuse of the practice. The first pertains to contingent circumstances where one's life is under threat from which there is no escape (at least not without an intolerable degree of suffering and a consequent burden upon others); or where some higher social end might be served by not resisting impending death. The second condition outlines circumstances toward the end of the life span, when life is shortened by the onset of a terminal illness or debilitation. Finally, a terminal fast is justifiable when it has been determined that in all probability natural death is imminent, and the time of life remaining can be estimated with reasonable certainty.

Arguments in favor of *sallekhana* appeal to certain basic principles, such as autonomy, self-respect, rational choice, nonviolence to self and others, and the virtue of courageous example to others. Beyond such appeals, however, Jains are aware of the practical difficulties of applying this concept in specific circumstances, given the development in India of sophisticated medical technologies that can prolong the clinical existence of patients with terminal illness or advanced debilitation.

For instance, Bilimoria asks, is *sallekhana* concealed suicide? Jains argue that suicide involves an element of coercion, for example, from emotional duress, and so violates the basic principle of *ahimsa* toward all life. The Jain practice, in contrast, entails no coercion, and only the dying person is implicated in violation of the noninjury principle. Second, is *sallekhana* voluntary or involuntary euthanasia, as debated in the West? Jains believe that euthanasia involves both the active participation of another person and interference with the body's natural biology and chemistry. Hence, the voluntary death of *sallekhana* does not equal mercy killing; in death by fasting there is no interference with the normal process of physical decay.

Jains realize, however, that permitting the withholding of food and nutrients in *sallekhana* suggests something analogous to the stance of those who accept passive but not active euthanasia. More troubling, some wonder if discussing *sallekhana* in terms of the typical scenario of the ailing but much-in-control and reasonably enlightened Jain is relevant to situations involving infants or children the severely mentally handicapped, or the incompetent. Is "consent," in other words, whether of an individual, a proxy, or a parent, the necessary condition for commending a final fast?

One response to the question of legality is that the Jain practice of terminal fasting is outside the jurisdiction of the law because it is religiously ordained. This view is held to be consistent with India's policy of secularism, understood here as giving constitutional freedom to each religion to pursue its own style of existence, even conceding certain privileges, rights, and interests to minority and socially disadvantaged groups. Under the Indian penal code, however, suicide and assisted suicide are criminal acts punishable by law, and all forms of self-instigated death fall into this

category. Recent legal deliberations in India on attempted suicide have elicited contrary judgments, each having important implications for the practice of *sallekhana*.

One court has argued that the fundamental right to life, personal liberty, and livelihood also includes the right *not* to live or be forced to live. Its ruling implies that in the eyes of the law the Jain practice is humane, dignified, and ethical and therefore an acceptable form of dying. Another court, however, questioned whether it is right for the state to adopt the position that persons unable to lead a dignified life are welcome to depart it. The court argued that while moral and social factors could lead one to attempt suicide, the law does not recognize these factors as relevant. The law is not obligated to give weight to religious practices that may legitimize voluntary death, without regard to the procedure established by law.

The implications of this latter ruling cause alarm for those holding the traditional Jain position, Bilimoria concludes. This more conservative interpretation of Indian law in the debate on voluntary death by fasting upholds the relevant portions of the penal code, does not support a fundamental right to die, and does not accept as binding in law any religious justification for this practice.

—Edwin R. Dubose

Practicing Scripture

Allen D. Verhey, "Scripture and Medical Ethics," *Bioethics Forum* 8, no. 3 (Fall 1992): 3–12.

Bioethics Forum, a publication of the Midwest Bioethics Center, devoted its Fall 1992 and Winter 1993 issues to a focus on "religion and medical ethics." This article by Allen Verhey (an extended version of which appears in his recently published Stob lectures, *The Practices of Piety and the Practice of Medicine: Prayer, Scripture, and Medical Ethics*, 1992) speaks to chaplains, ethicists, and other caregivers and explores the moral significance, and the problems, of reading Scripture with the suffering and dying.

Verhey embeds his arguments in a story recounted in Robert Coles's *Harvard Diary*. In Coles's

story, a dying Christian physician is frustrated and angered by a hospital chaplain (who could well be an ethicist) who is well-versed and relentless in “psychobabble” about the stages of dying but is illiterate and mute on prayer, Scripture, and the practices of piety. This dying man needs and wants “someone with whom to attend to God and to God’s word, not someone who dwelt upon the stages of dying as though they were ‘Stations of the Cross.’”

But, Verhey suggests, it is not only the language of psychotherapy that too often displaces attention to God during illness and crisis. Equally powerful in diverting the attention of caregivers from the resources of religious tradition is the generic “moral *esperanto*” of medical ethics.

Verhey does not claim that reading Scripture with the dying is a simple task. Rather, he begins by identifying four potential problems: (1) the “silence” of Scripture regarding our new medical powers; (2) the “strangeness” of Scripture—its words hailing from ancient times, customs, and languages; (3) the “diversity” of Scripture—it does not speak with one voice about sickness and healing; and (4) the “abuse” of Scripture and the abuses wrought with its sanction, such as endorsing pain in childbirth for women.

Nor is the world of modern medicine a particularly hospitable environment for reading Scripture. To begin with, modern medicine is thoroughly secular. It is material rather than spiritual, attending to the body and not recognizing the soul. Finally, medicine, as well as its context, is thoroughly pluralistic, a reality that argues for universal and generic moral principles and against particular premises of archaic religious traditions.

But Verhey is not ready to leave those who face suffering, dying, or difficult medical or moral decisions bereft of the strengths and resources of Scripture. In fact, he finds the failure to attend to Scripture “lamentable.” Not only are the human events to which medicine attends (birthing, healing, dying) profoundly religious, and not only is medicine peopled with caregivers and patients who, as Christians, seek to have their caring, suffering, and dying formed and informed by Scripture, but failure to attend to Scripture diminishes society itself:

A genuinely pluralistic society presumably profits from the candid articulation and

vigorous defense of particular points of view. The particular views of identifiable communities serve to remind pluralistic societies not only of the moral requirements for people to live together and die together peaceably, but also that such requirements are, indeed, minimal. If society ignores or denies the richer voices of particular moral traditions, it will be finally unable to nurture any character besides the rational self-interested individual, unable to sustain any community other than that based on the contracts entered by such individuals, and unable even to ask seriously “what should be decided” and not just “who should decide.”

Given that reading Scripture in the world of medicine is important, however problematic, Verhey next asks: how do we proceed? What is going on when the sick long to hear the words of Scripture spoken in a community, even of only two? Verhey’s answer counters a simplistic, literalistic, proof-texting approach to reading Scripture, an approach that creates many of the problems outlined above. Verhey instead draws upon moral philosopher Alasdair MacIntyre to describe the reading of Scripture as a *practice*, an activity with goods “internal to it” and internal standards of excellence that govern its performance. Practices like these are learned only in community, only through the tutelage of those more skilled, only by witnessing the practice in a multitude of contexts.

The corresponding goods are likewise acquired only through participation in the practice. Verhey identifies the fundamental good internal to the practice of reading Scripture as the good of “remembering.” Remembering transcends the intellectual recollection of bits of information and historical facts. Rather, it is a complex good that is necessary for the creation of identity, discernment, and community. In telling the story of Scripture, a community remembers its past and the ways this past is constitutive of its present identity. It remembers the stories of God—of who God is and how God acts in the world. It remembers the implications of God’s story for those who follow: “To remember that God gave manna, enough for all to share, [and] took the shape of the field unharvested for the poor. To remember [that] Jesus took the shape of discipleship.”

In learning the practice of reading Scripture, one also learns the standards of excellence that govern it.

Verhey identifies six paired virtues required to read Scripture well: holiness and sanctification, fidelity and creativity, and discipline and discernment. Holiness recognizes both that these writings are set apart and that those who faithfully practice must set apart “a time and a place to read them and remember.” Sanctification recognizes that the stories of Scripture—the stories of the creative and transformative power of God—must be set alongside all the stories of our suffering, dying, healing, and caring “until all the times and all the spaces of our lives are made new by the power of God.” Remembrance “provides identity” and requires fidelity, that is, the virtue of being ready “to live with integrity in that identity.” But true fidelity requires creativity, “for the past is past and we do not live in it.” Without creativity, fidelity can become at best anachronistic eccentricity; it can also render the identity outdated and therefore irrelevant. Finally, reading Scripture requires discipline and discernment. It requires that those who read Scripture be “ready to be a disciple, ready to follow the one of whom the story is told.” To follow well requires discernment, the virtue of recognizing “fittingness,” whether it is the “fit” between one passage of Scripture and the whole of it, or the “fit” between the parts of our lives—and our medicine—and the whole of the life remembered in Scripture.

None of this fits neatly into an ethical regimen that seeks checklists and flowcharts. But Verhey’s article challenges those who attend the sick—especially chaplains and ethicists—to understand the moral power and significance that reading Scripture holds for those who suffer and for their families. Verhey provides a framework for understanding the importance of this activity—for the sick, for caregivers, and for medicine.

—M. Therese Lysaught

The future of Catholic health care

Joseph Bernardin, “Crossroads for Church’s Health Care Ministry,” *Origins* 22, no. 24 (26 November 1992): 409–11.

Speaking at a meeting sponsored by the National Coalition on Catholic Health Care Ministry, Cardinal Bernardin of Chicago asked the American Catholic bishops for their assistance in meeting the challenges facing the Catholic health care system. Because a majority of Catholic hospitals, nursing homes, and professional schools are owned and operated by religious communities of men and women (referred to here as *congregations*), the relationship of the local bishop to these institutions has often not been articulated. Indeed, the dialogue between bishops and sponsors of health care institutions is affected by larger issues in the church, including the role of women in ministry and church teaching on sexuality. A variety of difficulties, such as threatened foreclosures and questions about sponsorship and mission in the face of declining numbers in congregations, have pressed the need for a clearer outline of the relationship of mutual support and accountability between bishops and the health care providers. Calling for cooperation in planning for a vigorous future for the health care ministry, Bernardin set out four challenges facing the bishops and the health care institutions.

First, sponsoring congregations are finding it more difficult to provide the personnel for leadership from their own declining membership. The church must be deliberate in helping prepare persons for leadership.

Second, though there have been good relations between the religious congregations operating health care institutions and the local dioceses, local bishops and the health care administrators may not communicate about concerns and calls for accountability until it is too late. Ongoing collaboration is required, though the structures of some congregations’ national health systems make this difficult. Members of the local church also need to be reminded that the health ministry is part of the church’s total mission and not just the responsibility of the sponsoring institutions.

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Third, fiscal pressures and cuts in public funding have made it difficult for some institutions to carry out parts of the sponsors' mission, such as maintaining commitments to health care for the poor and uninsured. In addition, an attitude of competition between local Catholic hospitals makes it difficult for bishops concerned about the future of Catholic health care to work with these sponsors on financial questions.

Fourth, bishops have a continuing role in health care advocacy. Though the church has been calling for comprehensive health care reform for over 20 years, its "constructive and distinctive voice" is still needed in national and local debate. Bernardin noted the unique

contribution that the church can make to this discussion as "defenders of human life and human dignity, providers of health care, purchasers of insurance coverage for our employees and . . . a community that serves and advocates for the poor and vulnerable."

Bernardin concluded by calling for more dialogue and collaboration at national and local levels between the bishops and the health care institutions to find ways to sustain and strengthen the Catholic commitment to health care.

—Agnes Coveney
Research Assistant



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1. The manuscript should be typed on one side only, on standard white paper, with margins of at least 1 inch. All material, including extracts and references, should be double-spaced. Manuscript length should not exceed 35 double-spaced pages.
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Examples

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